

# The Psychiatric Quarterly

OFFICIAL SCIENTIFIC ORGAN OF THE NEW YORK STATE  
DEPARTMENT OF MENTAL HYGIENE

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## THE PSYCHIATRIST AND THE PATIENT'S RELATIVES

BY KARL R. BEUTNER, M.D., AND RUSSELL BRANCH

In his daily work, in office or institution, the psychiatrist's main and proper concern is for his patients. His mind is occupied with the details of their illness and treatment; his thoughts are pre-occupied with all the complexities of a never-ending battle against human chaos itself. Perhaps it is not too surprising, then, that the appearance of a patient's relative often comes as the final straw to a back which already feels quite overburdened. For who of us has not seen the painstaking results of weeks of work undone in half an hour by a relative's visit? And which of us has never been cornered by an irate family member, to be harangued for deeds of omission or commission, to have our motives questioned and our methods reviled?

Whether one enjoys facing it or not, the problem is there; and it is much more than a mere question of public relations or personal discomfiture. It is, in demonstrable fact, a problem crucial to the patient's illness and to the treatment of it. And while the literature has accorded it this recognition, it also has afforded it scant discussion.

Perhaps the prevailing professional attitude finds its truest but unintentional reflection in a small book by Edith M. Stern.<sup>1</sup> To the writers' knowledge, this book has been widely recommended by psychiatrists and handed out in wholesale lots by institutions. Intended as a guide for the relatives of mental patients, it amounts to a summary of admonitions, of "do's" and "don'ts," for those persons. While one may not choose to quarrel with the specific advice offered, one may certainly question both its efficacy and the general attitude in which it was conceived.

Mrs. Stern opens her discussion with the statement that "the attitudes of relatives play a large part for better or worse," and then in a later chapter elucidates the proper attitude as including "courtesy, restraint, consideration, truthfulness and respect for authority." It would appear that the author, in gathering her material, has absorbed and reflected the underlying attitude of her professional advisers. Namely, the devout and pious hope that patients' relatives can—and will—do no better than to keep themselves out of the collective "hair" of the institution and its staff.

At the professional level, although still reflecting administrative concern, is a report on the problem as pertaining to an army hospital.<sup>2</sup> Here, of course, the problem of hostility in relatives is especially acute, since much of that focused on the hospital is hostility felt against the army as a whole. This study is limited to those relatives who aggressively insisted upon seeing the chief of neuropsychiatric service. It was found that after the staff had been encouraged to give brief therapy to these relatives, in the form of encouraging them to ventilate their feelings about the patient, rather than about the hospital, the number referred to chief of service fell to one a month, as against a previous rate of two a week. The author of the report concludes: "This type of interviewing appears to be of value as it favorably influences prognosis of the illness."

Other reports have emphasized the importance of the family's attitude, for therapeutic as well as administrative reasons. For instance, Kaplan and Wolf<sup>3</sup> see the family as the institutionalized patient's sole remaining link with the outside world—and one which must be strengthened if he is to be helped to return to that world. They point out the ways in which this link may be weakened, rather than strengthened, unless appropriate family attitudes are encouraged by the hospital staff.

More specific testimony was offered in the study made by the California Department of Mental Hygiene, of the effect of intensified and integrated treatment on chronic patients in Stockton State Hospital.<sup>4</sup> The results of this controlled experiment were both dramatic and gratifying, but one conclusion was underscored to this effect: *The patient's family must be considered an essential part of the therapeutic program.* The report points out that while the co-operation of the relatives was considered essential, the hospital's attempts to renew interest in the patient often merely produced increased anxiety, guilt, and hostility from the relatives. And since optimum treatment requires the active help of the relatives, it was evident that a strong working relationship with the relatives must be maintained from the beginning.

Psychiatrists, of all people, should know that it is one thing to grant the existence of a problem, and quite another to see it for what it really is. The problem in this case is not only one of hostility on the part of relatives, but also on the part of the psychiatrist.

Part of this hostility probably arises as a simple defense against the common and constant barrage of such questions as: "Why can't he go home?" "Why must you keep him in a ward with crazy people?" "Why aren't you helping him more?" It is obviously much easier to intimidate the relative than it is to answer his questions; much easier to browbeat than to explain. And especially is it easy for the psychiatrist to use his knowledge of psychodynamics in a perverted way: to augment rather than alleviate the relative's guilt feelings about the case, and thus to keep him at arm's length.

This is inevitably true when the psychiatrist fails, or refuses, to recognize the source of the relative's hostility or anxiety. If he returns that hostility with aggressive behavior, or if he offers non-ego-acceptable interpretations, he only reinforces both the hostility and the guilt feelings which produced it.

The feelings of guilt, of blame, of anxiety, which produce destructive behavior on the part of the relative can be readily understood by the psychiatrist if he regards them with but a modicum of the same insight and skill which he brings to his patients. For instance, in the previously-cited study of hostile relatives at an army hospital,<sup>2</sup> it was suggested that the aggressive drive of some to get to the top administrator represented a playing-out of the overprotective mother role, as compensation for feelings of guilt and rejection in connection with the patient. Ellison, in a brief paper published in *Lancet*,<sup>3</sup> described essentially the same process in the case of relatives who perpetually complained. In addition, he suggested their aggression as an attempt to fight the illness itself, either for their loved ones or to ward it off from themselves. He also mentioned the outside financial and social pressures, which found an outlet in the hospital setting where there was no need to conceal the situation.

There are other and more subtle ways, of course, in which the psychiatrist may be seduced into using his psychodynamic techniques, not for understanding, but as a weapon against the bothersome relative. As the inevitable target of hostility from his patient, he may be tempted to project it back against what he may consider to be its rightful source. The concept of mental illness as the result of, or at least as aggravated by, traumata inflicted upon the patient by his family supports this rationalization. Thus,

the psychiatrist eases the burden of his own responsibility by shifting the blame onto the family.

This mechanism was described in particular by a group of writers who examined the causes of termination in psychotherapy.<sup>6</sup> It was suggested that by apparently siding with the patient and taking up cudgels with him against his relatives, the therapist was actually seeking an "out" for his own anxieties about the case. By abandoning therapy with the patient for a fight with the relatives, he was literally encouraging an end to the therapy: i.e., forced removal of the patient by his relatives.

And all too often, if the psychiatrist must seek further support for his rationalization, he need not look far. He may already be faced with a serious deterioration in the patient's condition as a direct consequence of a relative's visit. Then the relative, having had all his own anxieties intensified by such unsatisfactory visits, threatens to invoke political pressure of some sort. This may only take the form of a demand to see the chief administrator, but it may also involve an appeal to a congressman or to the local press for an "investigation."

Obviously, such behavior on the part of relatives can only be labeled as "unreasonable," to say the least. In fact, it is a common observation in informal staff conferences that one finds almost as much psychopathology in the relatives of mental patients as among the patients themselves. Why, then, should we expect of these people a "normal" or "reasonable" reaction to circumstances of the most trying sort: that is, to the fact of psychosis in one who, to them, represents a major emotional investment?

Several examples may serve both to illustrate the problem and to point to the solution. A paranoid schizophrenic, with additional catatonic ailments, was treated quite successfully, with electric shock and psychotherapy, at a state hospital. His social recovery was indicated by the fact that after nine weeks of treatment, he had progressed from a closed ward to an open, working ward and was making good at a hospital job. About this time, however, he received a visit from his wife, upon whom he was extremely dependent. During the course of the visit he questioned her, obviously in a paranoid manifestation, about her possible relations with other men. The wife's response was to belabor him with an umbrella. The following day found the patient in the hydrotherapy ward, showing marked disturbance and complete loss of contact.

Visits by the wife were thereafter prohibited and the patient made some recovery again. However, the problem of getting him out of the hospital remained insolvable until psychotherapy was undertaken with his wife.

This was limited to the ego level only; no attempt was made to give her any insight into her own neuroticism, or to explain the unconscious processes involved. However, even though the attempt was made on a suggestive and repressive level only, it proved adequate for the purpose. The wife achieved some intellectual understanding of some aspects of her husband's illness, including the mechanism which led him to suspect her of infidelity.

Another case, seen in private practice, also demonstrated the benefits which may accrue from the psychiatrist's consideration of the family's role. The patient was a man of 48, successful in his career as an engineer, but subject to deep depression with suicidal impulses. Some initial relief was obtained with electric shock treatment, and psychotherapy was continued over a long period but with little real progress.

On the surface the family situation seemed unusually favorable: The patient obviously loved his wife very deeply and was genuinely proud of both her and their two sons, aged 15 and 17, who had already achieved marked success as athletes and school leaders. However, one important aspect of the case became clear only when the therapist, with the patient's permission, interviewed the wife.

Mrs. M. proved to be an extremely pretty, petite, intelligent, and altogether charming person. She was indeed, as her husband had boasted, so vivacious and attractive that even her teen-age sons were proud to "squire" her to community affairs and to share golf and other recreational activities with her. But it was quickly apparent to the psychiatrist that this flattering devotion to "Mom" on the part of the sons served, not only to achieve their own goals, but also to prevent most chances for real intimacy between the parents.

When it was explained to Mrs. M. what this unconscious competition was costing her husband in terms of self-respect at a time when he most needed her reassurance and devotion, she was able to see and accept the point immediately. With her intelligent co-operation, the emotional balance was shifted in favor of her husband, and a very real obstacle in the way of therapy was removed.

With his added knowledge of the family situation, the therapist was also better able to point the patient in the direction of his underlying problems.

It is not suggested, of course, that all—or even most—difficulties with patients' relatives are this simply remedied. It is true, all too often and all too literally, that the relatives of psychotic patients are themselves seriously disturbed. In some instances, interviews with the attending psychiatrist may encourage them to seek outside treatment for themselves—and sometimes with remarkable consequence for the patient himself.

The authors have in mind a young law student who had been on a back ward at a state hospital for four years, a severe catatonic whose acute break had come at the time of the divorce of his parents. His relatives were cultured, well-to-do, and most co-operative, but their visits were inevitably marked by acute exacerbations of the patient's symptomatology and had to be stopped.

Little progress was made until finally, at the suggestion of the staff psychiatrist, the mother herself undertook outside psychoanalysis. In a matter of only 12 weeks, the mother reported that she now felt capable of constructive visits with her son, and this indeed proved to be the case. The patient rapidly improved to such an extent that, only six months after the mother had begun her own psychotherapy, he was granted a leave of absence to his family.

While, as has been said, these examples may reflect unusually favorable circumstances, they do serve to indicate the necessity for a constructive approach on the part of the psychiatrist in his dealings with the relatives of his patients.

First of all, he must recognize the source of the relative's frequent hostility toward him and the institution. Obviously, this lies in the psychodynamics of a situation wherein the relative feels both guilty and threatened; and the psychiatrist must seek to alleviate this pressure by therapeutic interviewing, rather than by venting his own aggression and thus reinforcing both the anxiety and the hostility.

As suggested by Inwood from experience with the especially hostile relatives of army patients,<sup>7</sup> the situation may sometimes be crystallized for the relatives by suggesting that the patient be immediately discharged. The prospect of assuming full responsibility for the patient brings home to them quite literally the

fact that their difficulties lie with the patient, rather than with the hospital or staff. The key to the problem, as Inwood sees it, is in encouraging the relatives to discuss their feelings about the patient, and he concludes that "The effort and time consumed in dealing with hostile relatives is decidedly worthwhile. . . . This therapeutic interviewing should be considered a definite part of the patient's treatment whenever possible."

Second, and perhaps even more important than this immediate consideration of effect upon the patient's treatment, is the family's role in the over-all prognosis. Hospitalization of a mental patient represents, after all, a final rupture of family relationships and, to that extent, a rejection of the patient by his family. Yet by any constructive view of his task, the psychiatrist must see hospital treatment as a mere transitional process whereby the patient may be returned once again to his "real life"—to whatever extent his capacities will allow. In other words, release depends ultimately upon reconstruction of the dynamics within the family to the extent that the patient and his family are able to live together.

Frequently, of course, this reconstruction takes place spontaneously. But often it requires the helping hand of the psychiatrist who, with his skill and insight in dealing with guilty and upset persons, can turn the tide toward acceptance of the patient as he really is. Success may depend both upon the relatives' accessibility and the psychiatrist's availability for the task; but in any case the psychiatrist should neither fail to regard the relative as an essential factor in the patient's treatment, nor to remember that much may be accomplished in this regard by short-term suggestive psychotherapy. It is often enough merely to give the relative an intellectualized understanding of his importance to the patient and to his recovery, and thus to reinforce his ego structure rather than his destructive hostility.

One of the present writers has found this aspect so important in his own work that he has published, in collaboration with another writer, a small popular book encompassing both this orientation and this aim.<sup>8</sup> And in conclusion, one can perhaps do no better than echo the statement made by the chief social worker in the Stockton Hospital project,<sup>9</sup> when that project was reported at the Langley-Porter Clinic in San Francisco. She said: "No mentally

ill patient ever leaves a state hospital unless the relatives of the patient want him to."

#### SUMMARY

Both the literature and the writers' own experience point to the vital importance of eliciting co-operation rather than hostility from the relatives of mental patients. Improvement as well as deterioration in a patient's condition is often seen to hinge directly upon the attitude of his relatives. For that reason, as well as for the practical consideration of returning the patient to his family under the most favorable circumstances possible, the psychiatrist must recognize and attempt to relieve the source of anxiety in hostile relatives—rather than return their hostility, or try to hold them at arm's length. This can often be accomplished, with a minimum of effort but a maximum of benefit, by employing simple, suggestive psychotherapy in interviews with relatives.

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## THE PSYCHIATRIC APPLICATION OF VESPRIN\*

BY P. G. ILEM, M.D., AND A. SAINZ, M.D.

Vesprin, or trifluopromazine, has been used, and its clinical applications and limitations studied, for two years at Marcy (N.Y.) State Hospital, in a project involving 250 patients. Reports by Azima, Durost and Cahn<sup>1</sup> and by Rudy, Rinaldi, Costa, Himwich, Tuteur and Glotzer<sup>2</sup> had given the preliminary impression that vesprin was an effective and valuable phrenopraxic drug, being apparently as valuable and possibly less toxic than the parent drug chlorpromazine. Sainz<sup>3</sup> made a detailed study of the toxicity of this drug and concluded that it was far less toxic than chlorpromazine for the following reasons:

1. The blood picture is not substantially altered by vesprin. Although one case of agranulocytosis with a fatal outcome has been reported by Ayd,<sup>4</sup> this is the only such report, and the drug does not tend to produce leukopenias in patients sensitized to chlorpromazine.

2. The drug does not produce laboratory-discernible changes in hepatic function.

3. Vesprin produced postural hypotension in far less patients than those affected by chlorpromazine. The depressant effect on blood pressure is approximately half that for equal dosages of chlorpromazine.

4. Contact dermatitis, allergic reactions and maculopapular eruptions are very rare with vesprin. It is also questionable whether it produces photosensitivity except in the case of highly susceptible individuals.

5. Extrapyrarnidal or "parkinsonoid" reactions occur in a significantly smaller proportion of cases, and with less intensity with vesprin than with chlorpromazine, and when they do occur, they respond much better to the appropriate corrective medication.

These considerations led to the belief that this drug was preferable to chlorpromazine. In addition, the preliminary clinical findings at Marcy agreed with those of others, that the drug seemed to have more phrenopraxic action than chlorpromazine. The study reported here was of 250 patients, divided among the diagnostic groupings shown in Table 1.

\*From the Division of Research, Marcy State Hospital, Marcy, N. Y.

## DIAGNOSTIC GROUPINGS OF PATIENTS STUDIED

Table 1. Diagnostic Groupings

Groupings	Males	Females	Total
Recent schizophrenics (paranoid and catatonics) ....	40	58	98
Chronic schizophrenics (including paranoids, catatonics, hebephrenics and simples) .....	46	60	106
Psychoneurotics (anxiety) .....	10	14	24
Psychoneurotics (depression) .....	5	3	8
Psychoneurotics (obsession-compulsion) .....	0	4	4
Manic-depressives (manics) .....	2	2	4
Senile psychotics .....	6	0	6

## RESULTS

The patients included in these diagnostic groupings complied with the minimum standard symptomatology outlined by Sainz, Bigelow and Barwise.<sup>5</sup> Patients were evaluated according to the research division's usual technique, described elsewhere.<sup>6</sup> For the present study, patients were divided in three categories of results: Category 1 included patients who showed complete remissions of psychotic or neurotic symptomatology. Category 2 comprised patients who showed changes in symptomatology which could be attributed to drug action beyond any doubt, and which represented improvements in performance of individuals. Category 3 was made up of patients not beneficially affected by the drug. The results are shown in Table 2.

*Recent Schizophrenics*

It is the writers' impression that for counteracting the psychiatric symptomatology of the recent schizophrenic picture, particu-

Table 2. Summary of Results with Vesprin Treatment\*

Diagnostic groupings	Categories of Results		
	1	2	3
Recent schizophrenics .....	40	43	15
Chronic schizophrenics .....	10	48	48
Psychoneurotics (anxiety) .....	10	5	9
Psychoneurotics (depression) .....	0	1	7
Manic-depressives (manics) .....	2	2	2
Psychoneurotics (obsession-compulsion) .....	0	4	0
Senile psychotics .....	0	4	2

\*The weighted percentages of the results derived from the Murey Evaluation Scale (Ref. 5) and briefly summarized in Table 2 can be judged in more detail by study of Figures 1 and 2.

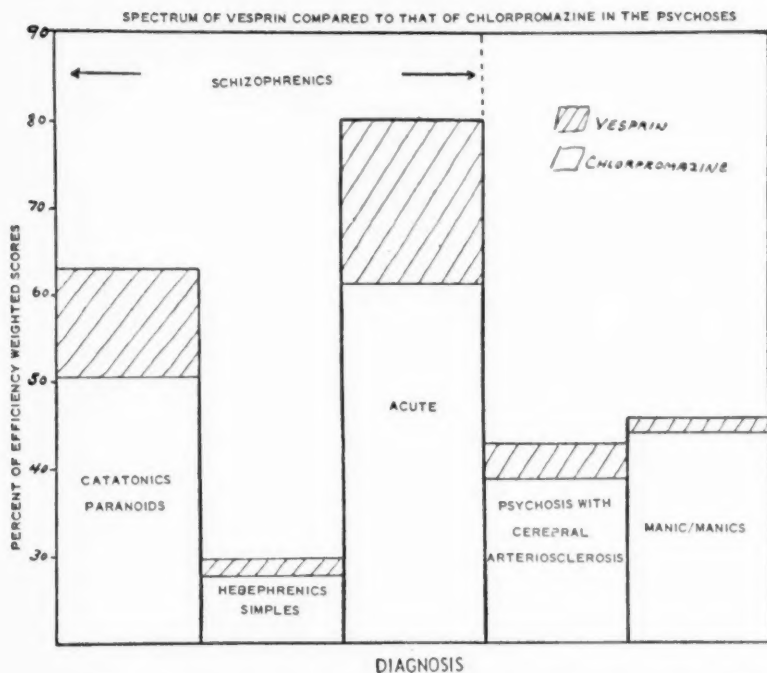


Figure 1. Both the vesprin and chlorpromazine percentage are adjusted or weighted figures, taking degrees of improvement into account, and showing average (mean) percentages of improvement as indicated by the Marcy Evaluation Scale (Ref. 5), which uses 72 indices in six categories of behavior to measure improvement. The vesprin percentages are those found in the present investigation; the chlorpromazine percentages are derived from standardization tests previously conducted at Marcy with the specified diagnostic groups (Ref. 5) and measured by the Marcy Evaluation Scale for degrees of improvement.

lary the thinking disturbances and the psychomotor dysfunctions, vesprin is more useful than chlorpromazine, not only because it produces remissions in a greater number of patients, but because of the better quality of improvement, as judged by the number and types of symptoms neutralized. Affectivity is more fluid and is warmer with vesprin. In addition, far fewer side effects are noticed. "Parkinsonian" reactions are the main problem. These appear in lesser proportions than with chlorpromazine, and in general can be easily counteracted. The dosage in this group was usually started at 50 mg., p.o., t.i.d., with meals, and 100 mg., p.o., at bedtime, and was progressively increased every four or five

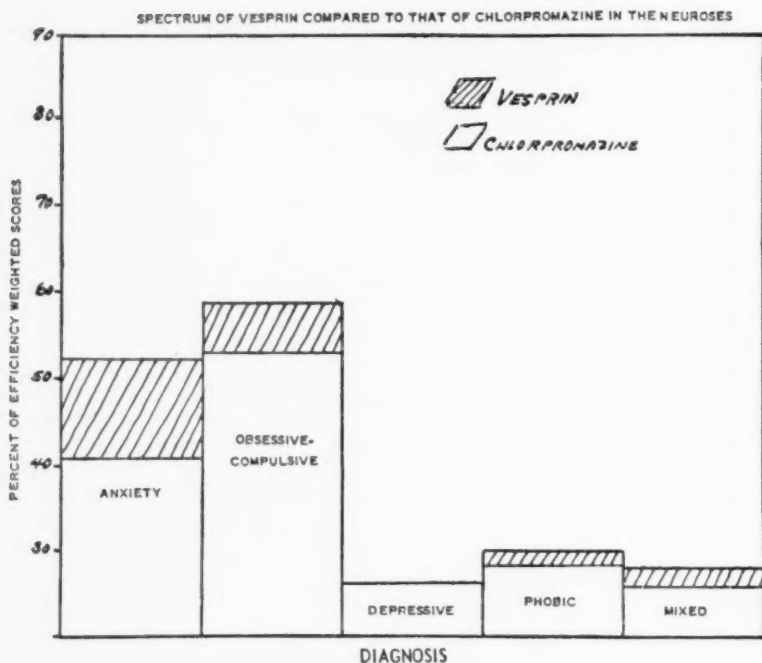


Figure 2. This figure gives the same information for the neuroses that is given in Figure 1 for the psychoses.

days until no further improvement was obtained. The increase would also have been halted if the side effects had become disabling, a condition which, however, did not occur.

The dosage, for the treatment phase, averaged 150 mg., p.o., with meals and 250 mg. at bedtime. The medication was given orally except when lack of co-operation or mental disturbance precluded such administration. Injection administration usually consisted of 20 mg. of vesprin, i.m., q.i.d.

The maximum dose given was to a paranoid schizophrenic woman, 37 years old, with very prominent delusional systems which culminated in hallucinatory hyperkinetic outbursts. This patient received 1,500 mg. of vesprin, p.o., q.i.d., and the only side effect encountered in this case was a moderate "parkinsonoid" reaction which was controlled by 200 mg. of parsidol given orally three times a day. For the control of severe hyperkinetic activity, regardless of etiology, it is the writers' practice to administer 40

to 60 mg. of vesprin, i.m., every two hours until the patient is sedated. This dosage is then spaced out by two hours at a time until the injections are being given four times a day, after which the medication is changed to oral dosages as soon as the patient is able to co-operate.

The important point to remember in the treatment of recent schizophrenics is that the medication must be increased until optimum results are obtained. Drowsiness, when it supervenes, should best be counteracted by rest in bed, as administration of analeptics such as ephedrine derivatives, counteracts the action of vesprin. In the experience at Marcy, parkinsonian reactions have never been so severe as to force discontinuation or reduction of the amount of medication; and they are usually well-controlled by adding small amounts of parsidol (or any other suitable anti-parkinsonian agent) to the regimen. Really serious hematological and hepatic dysfunctions were not encountered in this series.

#### *Chronic Schizophrenics*

In the chronic schizophrenia category, improvement was mostly in catatonic and paranoid patients. Some improvement, mostly in the psychomotor sphere, was found in hebephrenic patients, although their basic pattern of thinking was not changed. The simple and the hebephrenic groups showed the least benefits from this medication, and the hebephrenics showed the greatest amount of parkinsonoid reactions found, the incidence in their case being about 60 per cent. Parkinsonoid reactions, blurring of vision, dryness of the mouth and one case of mastitis made up the principal side effects found in the chronic schizophrenics. Oral medication was used throughout in this group. The dosage ranged from 50 mg., p.o., q.i.d., to 300 mg., p.o., q.i.d.

#### *Psychoneurotics*

Oral medication was employed throughout in treating psychoneurotic patients. The dosage ranged from 10 mg., p.o., q.i.d., to 100 mg., p.o., q.i.d., the average being 25 mg., p.o., t.i.d. Two cases of constipation that may possibly have been due to vesprin were found here; but the most difficult problem was akathisia, an extrapyramidal reaction characterized by subjective feelings of vibration and formication in the legs, coupled with an irresistible urge to walk. Patients so afflicted pace up and down in nervous agitation for protracted periods. Although vesprin was found to be, in the

case of anxiety neurosis, more effective than chlorpromazine, in that anxiety and fearfulness were much more rapidly and effectively controlled by vesprin, the same proportion of patients was benefited as with the parent drug. The tendency of vesprin to produce akathisia in neurotic patients is a drawback; because the akathisia induces a secondary type of anxiety which frequently is worse than the original. Of the nine patients in the anxiety group who did not improve, seven became actually worse.

In the patients with psychoneurotic depression, one showed a moderate improvement which was felt to be due to amelioration of his anxiety, but seven patients did not respond favorably and five of them got worse because of the parkinsonian reactions and akathisia. Only in the obsessive-compulsive group of psychoneurotics was there a distinct advantage to the use of this medication. Two patients of the four treated went into complete remissions in a short time; and the other two showed great improvement. Side effects, such as akathisia, were also observed in the obsessive-compulsives, but they were remedied by addition of small amounts of parsidol to the regimen.

#### *Manic-Depressives, Manic Type*

Four manic patients were treated with intramuscular and intravenous vesprin, in doses ranging from 20 mg., i.m., or i.v., q.i.d., to 60 mg., i.m., every two hours, for periods lasting as long as three days. All patients then received oral vesprin, from 50 mg., p.o., q.i.d., to 400 mg., p.o., q.i.d., for a month. In all four cases, there was improvement, to the extent that psychomotor excitement disappeared, but no changes in the psychotic mechanisms of thinking and affect were detected. It was felt that, in the manic phase, vesprin is no better than chlorpromazine or, for that matter, any of the barbiturates, and that reserpine or phenyltoloximine are much preferable. Two of the manics developed severe parkinsonoid reactions, which disappeared with the addition of parsidol to the regimen.

#### *Senile Psychotics*

Six senile patients, with prominent confusion and agitation as well as insomnia, were selected for special study. In four patients all symptoms disappeared after three or four days of treatment except the confusion, which never yielded. Two patients developed parkinsonism, and their agitation and restlessness were increased

rather than diminished. Otherwise no side effects were noted. Dosages ranged from 25 mg., p.o., q.i.d., to 100 mg., p.o., q.i.d. One patient received 20 mg., i.m., t.i.d. The usefulness of vesprin in this category is limited only by the appearance of parkinsonoid reactions.

#### *Comments on Treatment*

As already stated, the dosage of vesprin should be individualized for each patient; and the amounts mentioned—as a guide to what can be accomplished—indicate the lowest and top doses given in this series. Because of the paucity of side effects with this drug, and particularly because of the very low incidence of hematological and the absence of hepatic disorders, the therapist should err in overdosing rather than underdosing the patient. As important as the size of the dose, is the length of time in which the medication

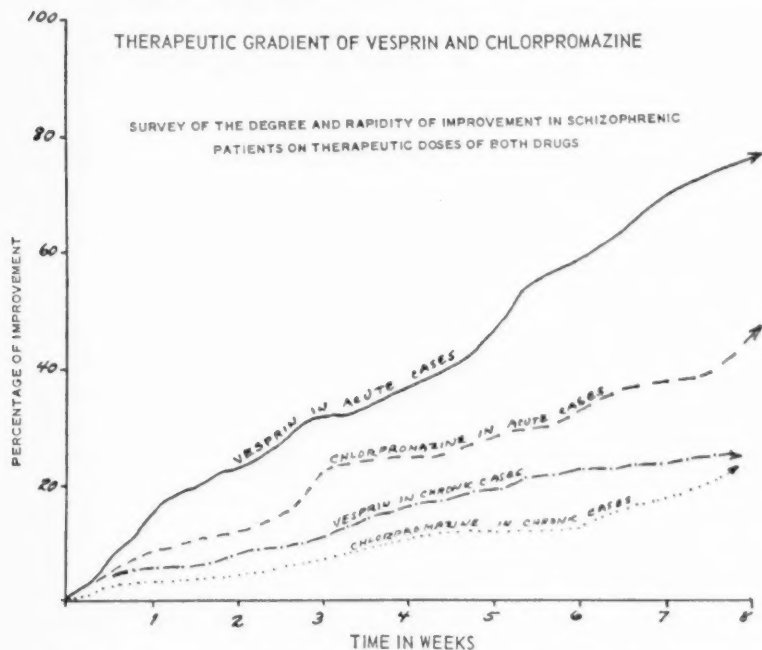


Figure 3. Relative rapidity of improvement and relative degrees of improvement—measured by the Marcy Evaluation Scale (Ref. 5)—brought about by vesprin and chlorpromazine. The comparison is for a group of paranoid and catatonic schizophrenic patients only, acute and chronic cases combined, not for the more varied group covered by the present paper.

should be administered. Figure 3 shows the rapidity of the drug action, as gauged by the percentage of improvement in symptomatology of the patient, in weeks of treatment.

The most bothersome side effects encountered are akathisia and other extrapyramidal "parkinsonoid" manifestations; but 80 per cent of the extrapyramidal side effects responded favorably to doses of 50 to 150 mg. of parsidol, p.o., t.i.d. to q.i.d. When a rapid improvement is desired, injection of 7.5 gr. of caffeine with sodium benzoate intramuscularly, eliminates this side effect in a matter of minutes.

#### SUMMARY

Vesprin is an effective phrenopraxic drug of the broad spectrum type comparable to chlorpromazine in its general applications. It is more effective and less toxic than chlorpromazine and should be considered the first choice for the treatment of schizophrenic conditions and the obsessive-compulsive neurosis. It is of value in the treatment of senile psychosis and valueless in the treatment of depressions and of manic psychosis—except, in the latter case, as an antikinetic. The drug is almost free from severe side effects and complications. It interferes less than chlorpromazine with the blood-pressure-regulating mechanisms of the body, but produces a substantial amount of extrapyramidal reactions. Of these last, akathisia is the most bothersome, and this limits the usefulness of the medication in ambulatory neurotics.

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## THE DIAGNOSIS OF PSEUDONEUROTIC SCHIZOPHRENIA\*

BY PAUL H. HOCH, M.D. AND JAMES P. CATTELL, M.D.

Numbers of psychiatric patients present a constellation of symptoms that initially appears to be psychoneurotic. However, careful scrutiny of the emotional and thought processes and of the behavior and symptomatology frequently discloses an impairment of regulation and integration that is not found in the psychoneuroses. The patients in question are often severely disabled, yet they do not have the classical accessory symptoms of schizophrenia. Such a state of affairs can lead to confusion about the selection of treatment for patients and the application of therapeutic technique.

The term and concept, pseudoneurotic schizophrenia, was proposed earlier in an attempt to delineate this poorly defined subgroup of the schizophrenic reactions.<sup>1</sup> Patients in this group were recognized as having schizophrenia, but with leading symptoms that are somewhat different from those seen in other types of schizophrenia. The original formulation has been modified and elaborated<sup>2, 3</sup> on the basis of extensive and intensive clinical studies of large numbers of patients. It has been possible for the writers to investigate this syndrome in hospitalized patients, clinic patients, and those seen in private practice over a number of years and under various circumstances.<sup>4, 5</sup>

There has been a progressively-increasing interest in this group of patients, as evidenced by the growing number of publications in this area. Some of these reports and discussions have given rise to semantic debates about the proper term to designate the syndrome, the diagnostic criteria for it and the psychodynamic and therapeutic connotations. Such controversy may be a commentary on the perplexity involved in trying to formulate the problems encountered and attain at least some solutions to them.

The adjective, borderline, appears frequently in the literature on this syndrome. It is used to modify any of a number of nouns, such as case, patient, state, psychosis, or schizophrenia.<sup>10-16</sup> Zilboorg introduced the term, ambulatory schizophrenia, in 1941; and he has published reports since that time, emphasizing that the

\*From the College of Physicians and Surgeons, Columbia University, where the senior author, Dr. Hoch, commissioner of mental hygiene, State of New York, is professor of clinical psychiatry, and the co-author is assistant clinical professor of psychiatry.

term is not meant to denote a clinical entity.<sup>17, 18</sup> The term and concept, latent schizophrenia, has been stoutly defended by Bychowski.<sup>19, 20</sup> One contributor has suggested that the concept of latent schizophrenia be differentiated from borderline schizophrenia as a separate syndrome.<sup>21</sup> Other terms have been proposed, including schizotype at the stage of decompensation,<sup>22</sup> diego-phrenia,<sup>21</sup> and pseudoschizophrenic neuroses.<sup>23</sup> One worker has demarcated what he terms pseudoneurotic depression from pseudoneurotic schizophrenia.<sup>24</sup> Another report suggests that these patients actually have schizophrenia simplex reactions and should be designated as such.<sup>25</sup>

The number of terms and the special and individual connotations given to them suggest a lack of clarity in the evaluation of this group of patients. The various uses of the adjectives, borderline, ambulatory, and latent, with various nouns, may have engendered misunderstandings in the diagnosis and treatment of the patients concerned. Each of these adjectives has a clear, denotative meaning in common usage. To endow each of them with one or several special connotations in psychiatric terminology may not be advisable, particularly if the special connotation bears little relation to, or directly contradicts, the usual meaning of the word. Each of these words is descriptive, yet "the ambulatory schizophrenias," a phrase which must be written in the plural, never the singular, and which does not denote a clinical entity,<sup>18</sup> is used to refer to patients in the particular group under discussion, whether they are ambulatory or hospitalized. It is not applicable to the many patients with simple, paranoid, catatonic, and hebephrenic schizophrenia who are ambulatory and not hospitalized.

The connotations of borderline, ambulatory and latent are unclear in designating what sort of illness these patients have. They imply that the patient is not neurotic and not schizophrenic but is in some limbo or vague, transitional state. The term, "borderline," can be found in any medical dictionary, and one definition is: "a case resembling two recognized disease conditions but not typical of either one."<sup>26</sup> Aside from other objections, the term is meaningless unless it specifies a borderline case of some specific disease or diseases. The term and concept are remnants from an earlier era of medicine in which diagnostic uncertainty and social stigma combined to mask various anxieties of the physician. Then, one might have "a touch of syphilis," or "a slight strain" (gonor-

rhea), and various euphemisms were used to becloud the diagnosis of tuberculosis. In addition, it is ironic that psychiatrists, who have been campaigning for years to eliminate such phrases as "a case of pneumonia in bed 12" from the medical vocabulary, should re-introduce "borderline case" to designate emotionally ill patients who have specific symptomatology.

This brings us to a consideration of "latent," a term commonly used to describe something that is not manifest. In the practice of medicine, it usually connotes the presence of a disease process not evident through ordinary clinical observation but discoverable through special procedures. A patient with no clinical manifestations of diabetes but with a diabetic blood sugar curve might be said to have latent diabetes mellitus or an asymptomatic patient with a positive Wassermann test, to have latent syphilis. If further investigations confirm the presence of diabetes mellitus or syphilis, the diagnoses and indications for treatment are clear.

The writers would like to emphasize that pseudoneurotic schizophrenia is a definite psychiatric syndrome with manifest symptomatology that can be observed by anyone who employs ordinary techniques of clinical observation in psychiatric interviews. The writers fail to see anything latent about it. They have found no evidence that pseudoneurotic schizophrenia is a transitional state between psychoneurosis or character disorder and gross psychotic symptomatology, though this has been implied by many and stated by some.<sup>10</sup> Some patients, who have the pseudoneurotic syndrome when they are first seen, develop a more classical schizophrenic syndrome subsequently. The majority, however, do not. Some improve remarkably with treatment and sustain their gains for years; others maintain a tenuous equilibrium; some remain essentially unchanged; and some are increasingly dominated by the pseudoneurotic symptomatology, with progressive disability. A detailed presentation of follow-up studies will be given at another time.

Reviews and evaluations of some of the literature on the psychopathological differences between this syndrome and the neuroses are available.<sup>11, 12, 27, 28</sup> Informative reports of panel discussions of the borderline case have been published.<sup>29, 30</sup> Data on psychodiagnostic testing have also been reported.<sup>31</sup>

Problems relating to the criteria for diagnosis, and the frame of reference in which diagnosis is made, have been discussed by

Knight.<sup>12</sup> Speaking of the term, borderline states, he remarks that it has no official status and provides no information about the patient except that he is sick and is not grossly psychotic. He suggests that the term conveys more about the uncertainty of the psychiatrist than about the patient's condition. Concerning the criteria for diagnosis, he states: "... attempts to build a classification of mental disorders by linking a certain clinical condition to each level of libidinal fixation, ... [have] presented a one-sided, libidinal theory of human functioning. The psychoanalytic contribution has been of major value but needs to be supplemented extensively with the findings of ego psychology, which have not as yet been sufficiently integrated into the libido theory. ... Reliance on the 'ladder' of psychosexual development, with the line of reality testing drawn between the two anal sub-stages, has resulted in many blunders in diagnosis—especially in the failure to perceive the psychosis underlying an hysterical, phobic or obsessive-compulsive clinical picture." On another occasion, discussing one of Bychowski's papers on latent psychosis, Knight<sup>30</sup> pointed out that some of the difficulties in diagnosing these patients arise because the diagnosis is essentially descriptive rather than dynamic. He went on to state that there are many ways to classify patients dynamically but that they all interfere with one another and that there is no single way that is satisfactory. One can add that the description of a clinical syndrome in psychodynamic terminology is not necessarily a dynamic formulation of the patient's illness.

The writers have concluded that in the present state of knowledge, pseudoneurotic schizophrenia is a valid and useful diagnosis. They believe that the term, pseudoneurotic schizophrenia, is justified, inasmuch as it describes the patient as having a schizophrenic reaction with a number of symptoms that resemble various psychoneurotic disorders. The mere use of the term can no more affect the course of the patient's illness adversely than the use of "borderline case," *per se*, can affect it favorably. It is the knowledgeability and the courage and skill of the psychiatrist that may affect the patient in a positive way. Whatever the attitude about the treatability of schizophrenia 30 or 50 years ago, during the infancy of modern psychiatry, there is evidence for some optimism today—during the early adolescent period of modern psychiatry.

The subject is so vast and so complex that it cannot be compre-

hensively presented in one paper. This report deals with one phase of the writers' studies: a brief formulation of the criteria for the diagnosis of pseudoneurotic schizophrenia. Subsequently there will be reports on the onset and course of the reaction, the pathogenesis and psychodynamics, and the various types of treatment, with particular reference to psychoanalysis and psychotherapy.

#### BASIS FOR DIAGNOSIS

The diagnosis of pseudoneurotic schizophrenia is warranted on finding several of the primary clinical symptoms of schizophrenia and a special type of secondary symptomatology. Not all the symptoms need to be present for the diagnosis. The terms, primary symptoms and secondary symptoms, were introduced by Bleuler.<sup>32</sup> The writers believe that they are useful in designating some of the fundamental and accessory symptoms in schizophrenia. In this presentation, the words "primary" and "secondary" are used as relative terms in a working hypothesis. No etiological connotations are intended in the use of these terms. More "primary" or fundamental signs and symptoms must be involved, but as yet they are undiscovered. The primary symptoms can be found in any patients with schizophrenia and are present in the pseudoneurotic form, though they may be less striking and intense than in some of the more gross forms of the disorder.

Intensive studies have made it possible to reformulate the primary clinical symptoms in clinicodynamic terms. The secondary symptoms of pseudoneurotic schizophrenia consist of a superstructure of many neurotic symptoms and mechanisms—a pan-neurosis; diffuse anxiety manifested in many areas of behavior—a pan-anxiety; and a great deal of sexual experimentation in fantasy and fact—a pansexuality. The primary and secondary symptoms used for diagnostic purposes are listed in Table 1.

Table 1. The Diagnosis of Pseudoneurotic Schizophrenia

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The Primary Clinical Symptoms:

1. Disorders of Thinking and Associations: Process; Content.
2. Disorders of Emotional Regulation: Form; Content.
3. Disorders of Sensorimotor and Autonomic Functioning.

The Secondary Clinical Symptoms:

1. Pan-Anxiety.
  2. Pan-Neurosis: Neurotic Symptomatology, Acting-Out Behavior and Character-Disorder Symptoms.
  3. Pansexuality.
-

It is convenient to formulate the primary symptoms in terms of disorders in thinking and associations; disorders of emotional regulation; and disorders of sensorimotor and autonomic functioning. The disturbances in thinking and in emotional regulation have been further subdivided into disorders of process or form and disorders of content. Dysregulation is usually found in all three spheres of functioning, and no sphere is postulated as being more fundamental in importance than the others. It is recognized that such a trisection of human behavior is artificial. This becomes more evident as one tries to delineate the disordered functioning in separate spheres and subdivisions. It is not clinically possible, for instance, to investigate the disorders of thought process or of emotional content in isolation. Each sphere of functioning partakes of all the others in a "unitary" or whole person. Thus, one can only study the clinical evidence of disordered thought process, for example, as influenced by thought content, by form and content of emotional dysregulation and by sensorimotor-autonomic dysregulation.

The outline which follows of the disturbances in the different spheres is nothing more than a delineation of certain aspects of the whole disordered behavior. Special emphasis, for example, is given to "disorders of thinking and associations: process" in the section under that heading, and to "disorders of emotional regulation: content" in the section under a separate appropriate heading. There is apparent repetitiousness in that a given aspect of disordered functioning is often reconsidered; but, in the reconsideration it is viewed from a new direction, and there is a shift in emphasis.

The organization of the outline has many deficiencies. However, the writers believe that it can lead to more definite and more refined clinical observations, while doing much to maintain a holistic concept of the patient. Thus, it is suggested that attention be directed to its operational aspects rather than to its value as a formal and static theoretical structure. Elaborations and clinical illustrations of this condensed outline will be presented in an extensive report at another time. The writers wish to emphasize that all the primary symptoms would probably not be found in a given patient in the pseudoneurotic group. A finding of several of these primary symptoms is significant.

*Disorders of Thinking and Associations: Process*

Table 2. Primary Clinical Symptoms of Pseudoneurotic Schizophrenia

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Disorders of Thinking and Associations: Process—

1. Evidence of characteristics of primary process thinking.
2. Disturbances in thought continuity and goal-directed thought.
3. Disturbances of thought flow.
4. Disturbances of awareness, attention, anticipation and concentration.
5. Impairment in the process of concept-formation.

## Disorders of Thinking and Associations: Content—

1. Content dominated by stereotyped, anachronistic concepts and attitudes.
  2. Distorted concepts of self, body-image, the world and the interrelationships of these.
  3. Rigid and distorted concepts of the meaning and utilization of intellect, emotion and behavior.
  4. Chaotic concepts of sexuality.
- 

The thought process can be variably disturbed at all levels of thought-functioning, from the initial perception of stimuli to the consciously recognized constellation of end products. Reactions to stimuli can be impaired in the realm of perception, integration and response, some of the aspects of which can be described in the following manner.

## 1.\*

There is evidence of the characteristics of primary process thinking, and these are probably fundamental to the other aspects of the disordered thought process.

*Condensation.* Ideas are related one to another on the basis of *pars pro toto* identification, despite incongruities of time, place and person relationships. An idea, having a superficial or partial resemblance to another idea, is regarded as being equivalent to it. Contrasting and unrelated aspects of the two ideas are overlooked. The patient fails to use discrimination in applying the idea, often selecting an inappropriate time and setting. For instance: Having had his advances warmly received by a blonde woman on one occasion, the patient concludes that blonde women are easily available for amorous purposes. In addition, a given idea often has multiple determinants, or embraces many elements, the "collective figures" and "composite structures" discussed by Freud.<sup>33</sup> Such a figure or structure may be used indiscriminately in thinking to represent any of the elements included in the idea. Thus, "blonde woman"

\*The numbers correspond to the numbered subdivisions of the tables under the same headings as those of the text—in this instance, the upper list of Table 2.

might—at one time or another, or more or less simultaneously—signify warmth, affection, attractiveness, maternal protectiveness, looseness tantamount to promiscuity, and numerous other physical and personality characteristics. Contradictory and inconsistent aspects of this idea are overlooked.

*Displacement.* Clear, conscious recognition of a given need or idea, of the aim and object in the gratification of that need and of the quality-of-affect\* accompanying these may be absent. Another need, idea, aim, object or quality-of-affect may be substituted for any similar element. Frequent shifts of need, idea, aim, object and quality-of-affect occur with great fluidity. Thus, sexual need might be recognized by the subject as a wish for aggressive activity with an inappropriate object and an attendant affect of anger. A need for assertiveness might be blocked or unrecognized in appropriate areas of activity, and be manifested in "taking a woman," with attendant feelings of triumph and accomplishment.

*Symbolization.* Condensation and displacement are freely used in the formation of symbolic representations which are alien to logical thinking. A word, phrase, concept, type of person, institution or action is endowed with special symbolic meaning that is unique to the patient. For instance, one woman regarded highly intellectual, "aesthetic-looking" men as "great minds" but as ascetics who are quite removed from interest in, and capacity for, sexual activity. Such a person is seen as a "great mind," and all his other attributes are disregarded.

There may be simultaneous acknowledgment and repudiation of a given need, aim, object, idea or affect. This is the characteristic of the primary process known as "no negation," one of the roots of ambivalence. For example, logic and the intellect are worshipped as the only attributes worthy of man, while emotion is repudiated as base and animal-like. Then the patient shows an excessive amount of anxiety, anger, elation or other emotion in his "intellectual" pursuits. Or again, one may be told that everyone has equal rights but the individual speaking has more (or less) rights than anyone else.

Dereistic thinking (i.e., thinking away from reality) is often present. Fantasy life becomes increasingly dominating, and the

\*Quality-of-affect refers to the dominant emotional feeling, whatever its quantity or intensity. Quality-of-affect includes love, hope, elation, fear, anger, guilt, despair and other emotional feelings.

events of daydreaming and nightdreaming are not clearly distinguished from reality experiences. Real happenings may be recognized by the patient as only the products of fantasy, thus warranting no action. More often, fantasy experiences are interpreted as possibly real, leading to confusion about reality or to untimely and inappropriate action. Other attributes and illustrations of this type of thinking are taken up in subsequent sections of this paper.

The characteristics discussed are often present in, and contribute to, other aspects of the thinking disorder, all of the aspects of which are interrelated. The disorders of the thought process and thought content, in turn, influence disturbances in other spheres of functioning. These will be described subsequently. Such disturbances in the other spheres of functioning likewise affect the thought process and content, often adversely. Further illustrations of disorders of the thought process will be presented in a consideration of disturbances of thought content, which is undertaken in one of the following sections.

## 2.

There are disturbances in the continuity of thought and in the direction of the thought process toward a tentative or definite goal. The goal of thinking is not clearly formulated nor is it well-sustained. The thought-goal may be sporadically pursued, shifted or abandoned. Continuity of thought toward the goal may become distorted or lost in secondary and tangential associations. Under ordinary circumstances of "normal" mentation, there is a selective facilitation of material pertinent to the thought goal, and the tangential or accessory material is automatically or voluntarily excluded. A frequent defect of thought continuity in the primary symptomatology is a failure of such selective facilitation of appropriate material. Instead, secondary associations intrude and material that is not directly allied to the thought continuity and the thought goal disrupts the continuity. The patients are often sensitive to irrelevant stimuli, and thought continuity is distorted by apparently accidental linkages and non-essential material. For instance, the patient begins to recount an important event of last week and becomes lost in debating whether it happened Wednesday or Thursday, and in considering the insignificant events of those days.

Emotional complexes frequently influence thinking. This proc-

ess can lead to disability in selecting past experiences that are appropriate to the immediate thought synthesis. This disability can be manifested through influence by complex-determined hyperamnesias or amnesias. Thus, a mass of unnecessary and minute details is recalled from one emotionally-charged experience in the past while important recollections from another experience are not available at all. Continuity of thought may be temporarily or permanently deflected in this way. Complex-bound determinants may invade perception, and immediate stimuli are perceived in a fragmentary or distorted way.

The diffuseness and vagueness in thinking may be characterized by avoidance of the specific and pursuit of the general, to the point of global abstractions. Thus, situations calling for concrete and literal thinking may be generalized to meaninglessness. Conversely, situations or stimuli requiring abstract or figurative handling are concretized to the point of absurdity. In certain situations and in some topics, the thinking may be quite clear and logical. Another aspect of the impairment of goal-directed thinking has been termed approximate thinking ("near-miss" or "off-target" thinking). It is characterized by associations that are parallel to the main thought synthesis and thought goal, or only secondarily related to them. This leads to conclusions that are not appropriate to the situation. In addition, one often finds rigidity in thinking, stereotypy of thought and perseveration of thought. In such circumstances, the thought process and goal are adamantly pursued despite clear and necessary indications to abandon them. Interruptions, necessary delays and appropriate shifts are not tolerated. The pursuit and completion of the particular thought sequence becomes the primary motivating factor; the means to an end becomes an end in itself. At times, specific stereotyped sequences of associations may be pursued repeatedly and endlessly—or to the point of exhaustion. In many instances, evaluation of the logicity of the on-going thought process and the thought goal is disturbed by doubting and indecisiveness with the result that action is often blocked.

### 3.

The progressive and even flow of thought is altered. Patients complain of experiencing acceleration of pressure of thought or speak of a feeling of forced thinking. At times, there is complaint

about the opposite phenomenon, and a retardation of thought is experienced. This is called thought deprivation and can become a true blocking or absence of thoughts. There may be difficulties in initiating, sustaining and stopping the flow of thought, with unevenness and unpredictability of thought flow.

#### 4.

There are disturbances of the processes of awareness, attention, anticipation and concentration. These disorders are based on, and implicit in, various other aspects of the disordered thought process. There are distortions of the process of achieving awareness of the self, the body-image, the world, time, and internal and external perceptions. Awareness of behavior and of the effects of behavior on the environment and on the self is disturbed. The process of achieving and maintaining such awarenesses is altered by the disturbances in thought continuity and thought flow as well as by disorders of emotional regulation and sensorimotor regulation which will be mentioned later. These alterations of awareness are often attended by feelings of confusion, detachment, haziness and unreality. The disturbances noted in this section are most important in the distortions in the process of concept formation which will be presented in the next section. Illustrations are given when disorders of thought content are considered.

Under ordinary circumstances, attention, anticipation and concentration vary remarkably according to the activity in which the individual is engaged. Certain kinds of behavior are more or less patterned and automatized, requiring little active concentration, special attention or special anticipation. One sees this illustrated in certain motor activities, such as some aspects of bodily care or in certain social situations, such as being in a relaxed atmosphere among friends. Among patients, one finds that ordinarily-automatized behavior patterns may be altered in various ways. Attention may be focused on behavior that is usually automatized, and there is distortion of anticipation patterns. In addition, there may be automatization and stereotypy of behavior which would ordinarily call for adaptive flexibility and a focusing of attention. An unselective and exaggerated awareness of stimuli may result in inappropriate recognition and distorted evaluations of minor perceptions, leading to incongruous major conclusions.

There may be inability to initiate and sustain concentration at will or to give complete and unqualified attention to a situation ("to lose one's self in a situation"). The patient often reports simultaneous awareness of participation in a situation and of being a critical spectator. Or he may speak of a simultaneous awareness of rationally-determined and emotionally-determined perceptions and ideas ("double registration"). For instance, a junior executive discusses a complex sales problem with his superior in a business-like manner. At the same time, he is observing the scene as an onlooker, watching his own behavior and evaluating the boss's emotional reaction to him. He keeps searching for any sign of fatherly approval or hint of disapproval. At times, the subjective emotional interest may break through to such an extent that he abruptly turns the conversation to his personal standing in the firm. Thus, two differently-determined views of a situation are maintained at a given time. Both are recognized, and one or the other may claim priority and find expression at a given moment.

5.

The process of concept formation is grossly affected by the impairments already noted. In addition the ability to delineate and maintain distinct categories is reduced or distorted. There is difficulty in integrating new and different experiences with existing concepts. Separate concepts are often maintained when fusion would be simpler and more expeditious. The symbolic conception of the object is often regarded as being the object.

*Disorders of Thinking and Associations: Content*

1.\*

Thought content is dominated by stereotyped, anachronistic concepts and attitudes (anachronistic in terms of individual history and development). Concepts and attitudes are rigidly maintained, often in isolation, and jealously cherished in static form, rather than in a malleable, operational form. Universal concepts are formulated on the basis of inadequate and distorted percepts. For instance: "Father was a frightening tyrant. Father had gray hair. Gray-haired men are frightening tyrants." This simple ex-

\*See lower list of Table 2.

ample also illustrates a number of the disorders of the thought process—for example, condensation, displacement, symbolization, concretization and disturbance in thought continuity, thought flow and the process of concept formation.

## 2.

There are distorted concepts of self, body-image, the family, the world and the interrelationships of these. The self may be conceived as having a chameleon-like ability to adapt to and control any situation. At the same time, there is constant fear of being conspicuous in an unflattering sense, of losing control and of being controlled by others. A young woman in her twenties feels she can dominate any social situation and be the center of adoring attention, an impression reasonably justified by the facts. She believes that she can manipulate her behavior or that of others to achieve any end she wishes. At the same time, or alternately, she conceives of herself as a helpless, unlovable child; a revolting, unlovable female and as being completely vulnerable to demeaning exploitation and abandonment by anyone who might seek a close relationship. Thus, an illusory sense of superiority and inferiority is maintained. Many situations are viewed by patients as signal successes, yet dismal failures. These evaluations, particularly the failures, are related to objective performance in only a fragmentary and distorted way. Process disorders of thought goal and continuity, thought flow, awareness and attention, and concept formation contribute to this kind of conceptual content. Of course, emotional and sensorimotor-autonomic dysregulation also participate in this dysfunctioning. Associated impairment of self-esteem, self-confidence and self-reliance are inevitable.

## 3.

Concepts of the meaning and utilization of intellect, emotion and behavior are rigid and confused. The patient attempts to function according to stereotyped labels and fixed formulas with the conviction that all problems can be solved by the intellect. There is an emphasis on absolute values, "black and white" standards, while discounting obvious breaches, ridiculous paradoxes and impossible dilemmas. A 30-year-old man, who held a responsible posi-

tion in an advertising firm and was a respected and stable citizen in exurbia, prided himself on his intellectual honesty and personal integrity. He scoffed at those who allow emotions to influence their logical thinking and rational behavior. However, he had come to treatment after having induced two 10-year-old boys, sons of neighbors, to practise fellatio on him. He could not understand how he had permitted this to come about; or why he had tortured and killed cats in the past; or had voluntarily smothered one of his own infants until she became blue. He expressed some shame and guilt about these activities, but they failed to influence his heightened ideas about the value of intellectual control and his superiority in this realm. He moved out of the community where he lived and sought treatment only on the suggestion of a judge and as an alternative to standing trial.

Concepts are stereotyped, ambivalent and confused about the meaning and experiencing of love and hate; pleasure and pain; fear, anger and guilt; assertion, aggression and compliance and about what is "worth-while" activity and what is valueless. Patients engage in endless ruminations and protracted debates about these concepts, often regarding them as absolutes about which the truth can be discovered through rational thought. They attempt to disregard the contrasting confusion of their feelings in these realms. Two patients spent an entire night debating: "Is it easier to love or to hate?"

#### 4.

Concepts of sexuality are chaotic. There is bewilderment about male-female anatomical differences and about oral-anal-genital differences and functions. Relationships of male and female equipment to male and female prerogatives in this culture constitute a further source of confusion. Sexuality is viewed with fascination, being regarded as dirty, dangerous and mysterious, yet as a panacea for all problems. All kinds of non-sexual functioning and experiences may be erotized, while the concept of pleasurable satisfaction of the sexual need may be neglected or repudiated. Other aspects of dysregulation in the sexual sphere are elaborated in several of the sections that follow.

*Disorders of Emotional Regulation: Form*

Table 3. Primary Clinical Symptoms of Pseudoneurotic Schizophrenia (Continued)

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*Disorders of Emotional Regulation: Form—*

1. Evidence of some of the characteristics of primary process functioning.
2. Low threshold to anxiety.
3. Heterogeneity of emotional response. Emotional volatility with dysregulation of emotional depth.
4. Inertia in initiating, sustaining and terminating emotional response.
5. Impairment of ability to select and regulate aggression and assertion.
6. Complex-bound emotional reactions.
7. Latent period between perceiving stimulus and conscious recognition of associated emotional reaction.
8. Somatization of emotional reactions.

*Disorders of Emotional Regulation: Content—*

1. Intolerance of tension, and diffuse anxiety.
  2. Impairment of feeling tone, and anhedonia.
  3. Impairment of empathy. Sensitiveness with low threshold to withdrawal reaction.
  4. Exploitation of others in effort to experience emotion.
  5. Emotional feelings repudiated. Intellectualization of emotion.
  6. Craving for stimulation; craving for protection and dependency.
  7. Striving for quick, magical gratification of needs.
- 

There are several disorders in the initiation and the organization of the emotional reactions.

## 1.\*

Some of the characteristics of primary process functioning are evident. *Condensation*: Affect or affect-eliciting stimuli are related to one another on the basis of *pars pro toto* identification, despite incongruities of time, aim, and object. *Displacement*: Any of several needs or affects may be substituted for a given need or affect. For example, sadness, guilt or fear may be recognized instead of anger; platonic love or anger may be consciously experienced instead of erotic interest. The given need or affect may be experienced, but another aim or object is substituted for the intended one. There may be displacement of both the quality of the need or affect *and* the aim or object. A given affect or need (or their substitutions) may be recognized, yet there is no conscious awareness of aim or object. There may be simultaneous awareness of polar affects (no negation); for example, love and hate; fear and anger and guilt; joy and sorrow. Simultaneous acknowledgment and repudiation—of a given affect, need, aim or object—can obtain. The patient may withdraw affect from reality aims and

\*See upper list of Table 3.

objects, and focus on fantasy aims and objects, failing to differentiate the realistic from the fantastic.

A number of the more manifest evidences of disorders of the initiation and organization of emotional reactions should be mentioned.

2.

There is a low threshold to the anxiety response, with a low threshold to experiencing it, and bewilderment in coping with it. An anxiety response may occur in reaction to neutral or minimally threatening stimuli. Situations or stimuli that are ordinarily reassuring may provoke anxiety. Anxiety may occur in association with any change in the immediate situation in which the patient finds himself, or with any change in his activity or location. The anticipation of anything new is especially threatening and new experiences are usually avoided unless someone else takes the initial step and serves as convoy.

3.

Heterogeneity of affective response may be present, with several different emotions occurring simultaneously or in rapid succession. Emotional volatility is seen, with rapid shifts in the intensity of the affect and dysregulation of emotional depth. The affective feeling or tone is often unpredictable and without apparent relationship to the consciously-recognized situation or thought content. Affect is insufficiently modulated, and there may be sudden, unexpected eruptions of "raw emotion"—rage, terror, ecstasy, or other strong emotion.

4.

One finds inertia in the initiating of an emotional response, in sustaining it, and in stopping it. There is often an inability to control an increasing intensity and momentum of response, despite recognition of the necessity for such control.

5.

Facility is impaired in the appropriate selection and regulation of assertion, aggression, compliance and passivity in many areas of behavior, with overtones of fear, anger, and guilt. Stimulus-appropriate responses are often blocked, and an ambivalent reaction obtains—leading to paralysis of response or explosive response.

## 6.

Often in response to apparently neutral stimuli, there are complex-bound emotional reactions, as well as stereotypy of affective reaction to a given stimulus.

## 7.

Following the perception of a stimulus, there is frequently a latent period before the conscious recognition of the attendant emotional reaction. This delayed response may be exaggerated, inappropriate and excessively prolonged, once it becomes manifest. The patient may not relate it to the provoking stimulus, feeling perplexed and frightened by the experience.

## 8.

The somatization of emotional reactions is a widely recognized, though poorly understood concept in the evaluation of clinical observations. A brief elaboration of its connotations is given in a later section of this presentation.

*Disorders of Emotional Regulation: Content*

This section deals with the content of affective feelings, experienced by the patient and evident to the observer objectively or through the reporting of the patient.

## 1.\*

Tension is poorly tolerated, and there is an urgent need to have expectations fulfilled immediately. Despite protestations to the contrary, fulfillment of these expectations has little to do with the underlying tension, and the phenomenon of apparent insatiability presents itself. Actually, there is diffuse anxiety in almost every area of behavior. This anxiety seems impervious to every effort for relief made by the patient or his environment. Patients are often bewildered in trying to account for this inexplicable anxiety. This bewilderment may produce secondary anxiety, further complicating the situation.

## 2.

Patients suffer a keen awareness of an impairment of feeling tone and lack of pleasurable gratification of needs. The experience of no feeling and no pleasure (anhedonia) is accompanied by much anxiety.

\*See lower list, Table 3.

## 3.

There is recognition of an impairment of the intercommunication of emotional feeling (empathy). Patients are oblivious to, or suspicious of, positive, friendly emotions in relationships with others. Neutral or hostile emotions in others are received with hypersensitivity, and there is resulting confusion about the relationships, especially if they are fundamentally affectionate ones. There is a reaction of withdrawal and seclusiveness, and neutral experiences become meaningful in ego-referential terms.

## 4.

The effort to experience emotional feeling and pleasure is often associated with partially conscious attempts to exploit the environment—either persons or activities. A specific characteristic of a favored person may be emulated, based on the premise that to do as he does will facilitate feeling as he feels. Such attempts at vicariously experiencing through others, usually produce a caricature of normal behavior, often with rapid disillusionment. Closely related to this is self-imposed participation in overvalued activities, or in activities with favored persons, as a panacea to bring the experiencing of emotional feelings and the finding of satisfaction in living. However, the patient maintains a distance from reality, using the activity or person as a cushion—or as a convoy. Social, sexual, intellectual, or aggressive activities may be involved. In those who feel apathetic, dead or nonfunctioning, there is a tendency to reinforce emotional feeling, in order to feel more alive and functioning. This may lead to provocative behavior and a display of aggression, which often results in the other person retaliating in kind. For instance, one woman feels dead and empty, so she becomes aggressive and starts a quarrel, and others in her household respond accordingly. This makes for a difficult domestic situation, but it has given her the feeling of being alive for half an hour.

## 5.

Emotional feelings may be repudiated as signs of weakness or as painful and confusing experiences. There is often associated boredom and expressions of indifference, leading to efforts to handle emotion by intellectual means.

## 6.

There are great dependency needs, with a craving for protection; yet protection and dependency are hostilely denied and rejected. Likewise, there is an eager pursuit of stimulation, with a simultaneous effort to avoid it; or there is periodic seeking-out of activity, followed by periods of withdrawal.

## 7.

A wish for quick, magical gratification of all needs is present, with concomitant denial of needs and of the striving for gratification.

### *Disorders of Sensorimotor and Autonomic Functioning*

Table 4. Primary Clinical Symptoms of Pseudoneurotic Schizophrenia (Concluded)

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Disorders of Sensorimotor and Autonomic Functioning

1. Impairment of integration of sensory perceptions.
  2. Impairment of ability to select and maintain motor responses.
  3. Somatization of emotional reactions. Autonomic dysfunction.
  4. Impairment of sensorimotor-autonomic integration in psychosexual functioning.
  5. Energy dysregulation. Intolerance of sustained activity toward a future goal.
  6. Pursuit of sensory and motor patterns as substitutes for stimulus-appropriate thought, feeling or action.
- 

## 1.\*

There is an impairment of integration of sensory perceptions, with variable distortions of self-image, body-image, and world-images. Neutral situations, perceived as threatening, may elicit feelings of change in self-image, body-image, and world-images.

## 2.

One finds a dysregulation of the integrative capacity to select and maintain homogeneous and appropriate motor responses. There are disorders of verbal and nonverbal communication. In an unfamiliar social situation, the patient is awkward, clumsy, stammering and physically *gauche*.

## 3.

In some patients, there is an apparently exaggerated somatization of emotional reactions. Various organ systems inappropriately become organs of attempted emotional expression or at-

\*See list, Table 4.

tempted need gratification. There may be displacement of the need-gratification discharge to the substituted organ system, though not necessarily. For instance, a patient experienced feelings of calm and well-being, and of being cleansed, after a migraine attack. Autonomic and voluntary nervous systems may be involved, and there may be distorted sensorimotor behavior or autonomic dysfunctioning in any of several systems: cardiovascular-renal, gastro-intestinal, genito-urinary, respiratory, musculoskeletal, tegumentary, or neuro-endocrine. Evidences of the disability may be acute or chronic, relatively continuous or episodic. Disorders of function may or may not be accompanied by temporary or by irreversible organic lesions.

4.

An impairment of sensorimotor-autonomic integration in psychosexual functioning may be present. This is often related to diffuse sexual experimentation in pursuit of gratification. There are associated disorders of arousal and of discharge in relationship to stimulus, time, aim, object and emotional context, with subsequent emotional reverberations that are often somatized.

5.

Energy dysregulation is often found, with impaired ability to initiate, sustain and stop activity. Patients report that they experience a feeling of no energy or of excessive energy, either of which may occur out of appropriate context. A low threshold to fatigue or a very high threshold are frequent complaints. The ability to initiate and sustain energy for a given task is unpredictable. There may be inexplicable "binges" of hyperactivity or underactivity. Sustained activity toward a future goal is tolerated poorly, and, therefore, performance slumps. An appraisal of a cross-sectional or longitudinal segment of functioning discloses a scattering of performance within and among various areas of behavior.

6.

Various sensory and motor patterns, mundane or bizarre, are pursued as substitutes for stimulus-appropriate thought, feeling or action. These include certain aspects of "acting-out" behavior, some compulsive acts, ties, and certain anesthetics and paresthesias.

*The Secondary Symptoms of Pseudoneurotic Schizophrenia*

Each of the subgroups of schizophrenia is characterized by a number of prominent, secondary symptoms. The diagnosis of the pseudoneurotic type is based on the presence of the primary symptoms plus the secondary symptomatology of pan-anxiety, pan-neurosis, and pansexuality. See Table 1.

## 1.\*

The term pan-anxiety is used to designate diffuse anxiety, the presence of which is marked by special intensity, duration and pervasiveness. The intensity may vary from vague disquietude to panic, but the subjective experience of anxiety is almost constantly present and is frequently dominating. Whether this anxiety is immediately obvious to the examiner depends on the situation and on the defensive techniques of the patient. It may increase or decrease in intensity, abruptly and without apparent relationship to external circumstances. A massive anxiety response may occur in reaction to relatively minor stimuli and may continue long after these stimuli have ceased. Every area of behavior may be pervaded by marked anxiety at one time or another, often unpredictably. It is a striking finding that anxiety persists as an important component of affective feeling tone in spite of many defensive maneuvers and symptoms, which rarely prove successful in allaying it.

## 2.

The presence of several different types of neurotic symptomatology is specified as pan-neurosis. There is usually a broad constellation which may include obsessions, compulsions, phobias, hysteria (with dramatizing or dissociative phenomena), depression, hypochondriasis, depersonalization phenomena and neurasthenia. Whatever the leading symptomatology may be, a survey of the illness, past and present, discloses numerous neurotic mechanisms occurring simultaneously or successively. As the course of the illness is followed, with or without treatment, shifts in the leading symptomatology can be observed. These changes in the symptom constellation have been regarded by some workers as therapeutic gains, often erroneously.

At times, the obsessions and phobias may be tantamount to delusions. It may be difficult to differentiate some of the deperson-

\*See "The Secondary Clinical Symptoms," Table 1.

alization phenomena from obsessions, delusions and depression. Oscillations of mood, of affect, of energy availability, and of the pursuit of stimulation must not be mistaken for a manic-depressive disorder, as they sometimes have been.

Patients with pan-neurosis usually have a secondary depression which is clearly related to the intensity and persistence of the illness. Primary depression, sometimes obviously reactive, also occurs, though less frequently. Most of these differentiations are pertinent on a descriptive level in distinguishing pseudoneurotic schizophrenia from psychoneuroses and from other psychoses. Such delineations become particularly important when one attempts to make a single psychodynamic formulation of an illness which involves the dynamics of so many symptoms.

Another type of neurotic symptomatology warrants inclusion under the term pan-neurosis. Symptoms of this type are manifested, for the most part, in social behavior and are often designated as one or another type of character disorder. For convenience, one can refer to acting-out, or dramatizing behavior; antisocial behavior and drug-dependent behavior. Each of these types can, and often does, involve the others, but each can probably occur alone. A good deal of acting-out behavior and some drug-dependent behavior is not antisocial according to the usual connotation of that term. Most antisocial behavior probably has components of acting-out and may be related to drug-dependency or to the use of alcohol or drugs. The antisocial behavior may be aggressive or sexual; impulsive, compulsive, or carefully planned; violent, or seductive and quiet (the last including the behavior of the swindler, extortionist, and impostor in either the socio-economic or the sexual sense).

These character disorder symptoms shade into the third criterion of pseudoneurotic schizophrenia: pansexuality. However, the writers feel that sexual behavior warrants special consideration.

### 3.

Pansexuality is the term and concept used to designate the more manifest aspects of the chaotic sexual organization and functioning of pseudoneurotic patients. Every conceivable variation of stimulus; of sensory and motor activity; of physical and emotional context; and of object and aim is pursued—in fact, in fantasy, or in both. These variations include the polymorphous perverse

activities of infantile sexuality, as well as many other combinations and permutations of activities and behavior. The goal of this behavior is to relieve sexual anxiety and to achieve acceptable sexual gratification without complicated and painful reverberations. The frantic and diversified efforts and activities testify to the lack of success.

The various manifestly sexual pursuits just mentioned are also used in misguided efforts to deal with problems of identity, emotional control, and discharge of emotion, as well as being used in relating to others, establishing dependency relationships or in terminating such relationships.

The frequency and quality of the sexual performance of this group range from zero to the level of the sexual athlete. The quality of the subjective experience is usually impaired, either during the act or through subsequent overtones of shame, guilt, and anxiety.

Patients often seek treatment, or are advised to, on the basis of some type of deviant sexual behavior, such as homosexuality, or on the basis of fantasy and fear of it. Such behavior may or may not be antisocial in the sense that it has been harmful to others or has attracted the attention of law-enforcement agencies. Closer study of these patients often discloses that homosexuality, for instance, is only one pursuit in a large repertory of sexual fantasies and activities. As the others become clear it is evident that there is impairment in performance or in satisfaction in all the pursuits.

#### DISCUSSION

An effort to outline the criteria for the diagnosis of pseudo-neurotic schizophrenia necessarily leaves many questions unanswered. A re-statement and elaboration of the primary symptoms of schizophrenia is fundamental to the concept of pseudo-neurotic schizophrenia and lays the foundation for subsequent presentations on this syndrome. A survey of the symptomatic superstructure of anxiety, and of neurotic and sexual manifestations is necessary to complete this preliminary picture. Other clinical illustrations of various aspects and phases of the illness must be offered at another time.

A large part of this paper is devoted to a consideration of the primary symptoms of schizophrenia. A complete presentation is not possible at present. As knowledge and experience increase,

some parts of this one will be rephrased, and there will be additions. The symptomatology described in each category or sphere of functioning is characterized by a number of descriptive statements. Each descriptive statement has numerous psychodynamic connotations and, most likely, has genetic and biochemical connotations. The idea of offering a reasonably comprehensive psychodynamic formulation of the behavior described is a challenging one. The writers hope to present some suggestions in this realm in the future.

The objection can be raised that any of the dysfunctions mentioned in the primary symptomatology can occur in normal individuals under special circumstances. Bleuler enunciated this fact in 1911.<sup>32</sup> The number, intensity and duration of the primary symptoms present at a given time would seem to be of crucial importance. In addition, the appropriateness of the symptom to the initiating stimulus, and the ability of the subject to select or reject a given response must be important criteria in evaluating the relative degree of psychopathology present.

The role of anxiety in the formation of the primary symptoms is not clear. Anxiety, its vicissitudes, and the defenses against it are prominent in every psychodynamic frame of reference. Many schizophrenic symptoms may be regarded as means of coping with anxiety or defenses against it—a restitutive function. It is a common clinical observation that many of these symptoms increase in intensity with increasing anxiety. Then certain symptoms become progressively more dominating, toward the point of being totally disabling—a disintegrative effect. Some of the symptoms appear to be essentially restitutive and some seem to have a disintegrative effect at certain times. The more specific issues—as to which symptoms are restitutive and which are disintegrative, and when—remain controversial.

To the extent that the symptoms are related to basic deficiencies, constitutionally or environmentally determined, many of them may produce anxiety, and there must be emerging defense mechanisms against this anxiety. The defenses in turn may be indifferently successful or may be unsuccessful and lead to more anxiety of variable intensity. In any event, the necessary for other, more symptomatic, more restricting and inhibiting, defensive mechanisms is evident. Thus, by the time the patient reaches the psychiatrist with his illness, we have, figuratively speaking, layer upon

layer of anxiety and defensive maneuverings—at best a sort of convoluted onion with its many layers. Nevertheless, it must be recognized that a person may have a great number of these primary symptoms and somehow maintain a tenuous equilibrium, at least temporarily. Such apparently restricted and inflexible people still have some flexibility and adaptivity, and this fact makes treatment possible, often with striking gains.

The secondary symptoms of pseudoneurotic schizophrenia seem to occur, in some instances at least, as a reaction to a progressive increase in anxiety and a progressive failure of any restitutive value that the primary symptoms may have. Many of the secondary symptoms can be recognized as developments of various primary symptoms, or combinations of such symptoms. More puzzling, is the "selection" of a specific constellation of "anxious," neurotic, acting-out and sexual phenomena. A particular constellation has prominence for a time, and then the emphasis may shift radically, for example, from obvious depression as a leading symptom to a predominantly phobic syndrome which gradually includes obsessive phenomena.

The incidence of pseudoneurotic schizophrenia is not known, though the writers have the clinical impression that it is much more common than realized. The course of the illness has not received much attention in the past. Data which the writers have assembled on incidence and course will be reported at another time. The etiology of schizophrenia is not known; thus, the etiology of the pseudoneurotic type is unknown. A number of the psychodynamic mechanisms in the primary and secondary symptomatology warrant comment. This will be presented in the future, along with some speculations on the pathogenesis of this syndrome and suggestions about the selection of treatment and the technique of psychotherapy.

#### SUMMARY

1. Some of the literature on pseudoneurotic schizophrenia is reviewed, as well as literature on the other terms which have been used to designate the pseudoneurotic group.
2. A re-formulation of the primary symptoms and secondary symptoms of pseudoneurotic schizophrenia is given, thus clarifying the criteria for diagnosis.
3. The primary symptoms are formulated in terms of disorders in thinking and associations; disorders of emotional regulation;

and disorders of sensorimotor and autonomic functioning. The disturbances in thinking, and in emotional regulation, are further subdivided into disorders of process or form, and disorders of content.

4. The secondary symptoms are pan-anxiety, pan-neurosis, and pansexuality.

5. A short discussion raises a number of unanswered questions and mentions forthcoming material on incidence, course, psychodynamics, and psychotherapy of pseudoneurotic schizophrenia.

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## TREATMENT BY HEMISPHERECTOMY OF NINE CASES OF SPASTIC HEMIPLEGIA, SEVERE MENTAL RETARDATION AND INTRACTABLE EPILEPSY\*

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### HISTORY

The first hemispherectomies were carried out by Dandy in 1923—the reports were published in 1928—for infiltrating gliomas of the right hemisphere. The patients died because of the progressive growth of the malignant tumors; but it could be demonstrated that a subject can survive the removal of the right hemisphere, suffering postoperatively a flaccid hemiplegia and a permanent hemianesthesia.

Interventions identical to those performed by Dandy and for the same indications were performed by Evans, Rowe, O'Brien, and Zollinger. The latter performed, for the first time, a left hemispherectomy in a right-handed person.

In 1940, Gardner carried out a right hemispherectomy for a huge astrocytoma, without excision of the caudate nucleus. Ten years later, Bell and Karnosh published a detailed study of the psychomotor state of this patient, and concluded that the result was functionally and socially satisfactory.

In 1938, MacKenzie carried out the first hemispherectomy for a cerebral scar. However, it was not until Krynauf reported a series of 12 cases in 1950 that attention was duly paid to the possibility of treating, by hemispherectomy, syndromes caused by malformed or sclerotic brains. He clearly pointed out that the most distressing symptoms derive from dysfunction rather than loss of function on the part of the diseased hemisphere.

Contributions to the procedure have become numerous in recent years, particularly from Continental neurosurgeons.

### PATHOLOGY

The pathological alterations for which hemispherectomy is indicated are, as a rule, grossly evident. They consist of simple atrophy, more or less diffuse; cystic degeneration (porencephaly, pseudoporencephaly, cyst); cicatricial sclerosis, congenital anom-

\*The work reported here—done at Central Islip (N.Y.) State Hospital—was partly supported by a grant of the Sister Kenny Foundation.

alies (pure cerebral hemiatrophy, microgiry, heterotopy). The most positive indications for hemispherectomy are unilateral lesions. The etiological factor is frequently a severe trauma or an infectious process. The frequent finding of a thrombotic occlusion of a major vessel in postinfectious encephalopathies leads one to think of an acute endoarteritis concomitant with the encephalitis. In these cases, there is an area of atrophy which delimits the distribution of one or two thrombotic vessels. It is, however, conceivable that, at least in certain cases, agenesis is the cause of the vascular occlusion.

#### CLINICAL SYMPTOMATOLOGY

*Motor Signs.* The patients present a hemiplegia or hemiparesis, with loss of fine, distal movements, increased deep reflexes, pathological reflexes and more or less muscular hemiatrophy. The paralyzed side presents increased resistance to passive stretching, with associated contractures, bony deformities and ankylosis.

*Sensory Disturbances.* The patients present gross sensory deficits, particularly in epicritic sensibility. Mental retardation and speech difficulty, when present, make testing very difficult and inaccurate).

*Sensorial Disturbances.* The most common sensorial disturbance is a hemianopic defect.

*Speech Difficulty.* Speech disorders of varying degree are present in cases of right-handed persons with lesions of the left hemisphere.

*Epilepsy.* There are attacks of epilepsy of different types: grand mal, petit mal, Jacksonian, status epilepticus. No, or very little, improvement is gained in the frequency and the severity of the attacks by placing the patients on high doses of anti-epileptic drugs. Frequently the rate of the seizures is such as to require constant care.

*Mental Retardation and Behavior Disorders.* Mental deficit varies from complete idiocy to mild retardation; but, as a rule, the patients rate very poorly when tested with the Wechsler-Bellevue or the Binet-Simon. Associated with the mental retardation, is the behavioral problem expressed by instability, impulsivity, aggressiveness, restlessness, and spastic tendencies.

## NEURORADIOLOGICAL FINDINGS

*Pneumo-encephalography.* The most common finding in these patients is represented by cortical atrophy, much more marked on one side, with conspicuous dilatation of the lateral ventricle of the diseased hemisphere.

*Arteriography.* Arteriography does not always reveal abnormal findings with the exception of stretching and upward displacement of the anterior cerebral artery in cases in which a dilatation of the third ventricle is present. In some cases, a thrombosis of the internal carotid artery, or of one of its branches, is demonstrated.

*Electro-encephalographic Findings.* EEG abnormalities vary. On the diseased side the most frequent findings are: absence of alpha rhythm, slow low voltage activity with spikes, or spikes and waves. The so-called "normal" side also frequently exhibits an abnormal EEG, slow polyrhythmic formations being present.

*Indications for Hemispherectomy.* The only symptom necessary to justify hemispherectomy is the motor deficit on one side, associated with hemiatrophy. However, other symptoms are to be expected. Of all possible combinations, four are regarded as the most common:

1. Chronic infantile hemiplegia with spasticity; behavioral and character disorder; epilepsy of the cortical type; normal or almost normal mental level; pneumo-encephalographic findings, with atrophy more marked in an area which, the arteriogram shows, is not supplied with blood because of vascular thrombosis; unilateral low voltage with interpolated spikes, or spikes and waves—even in association with some abnormal activity on the opposite side.

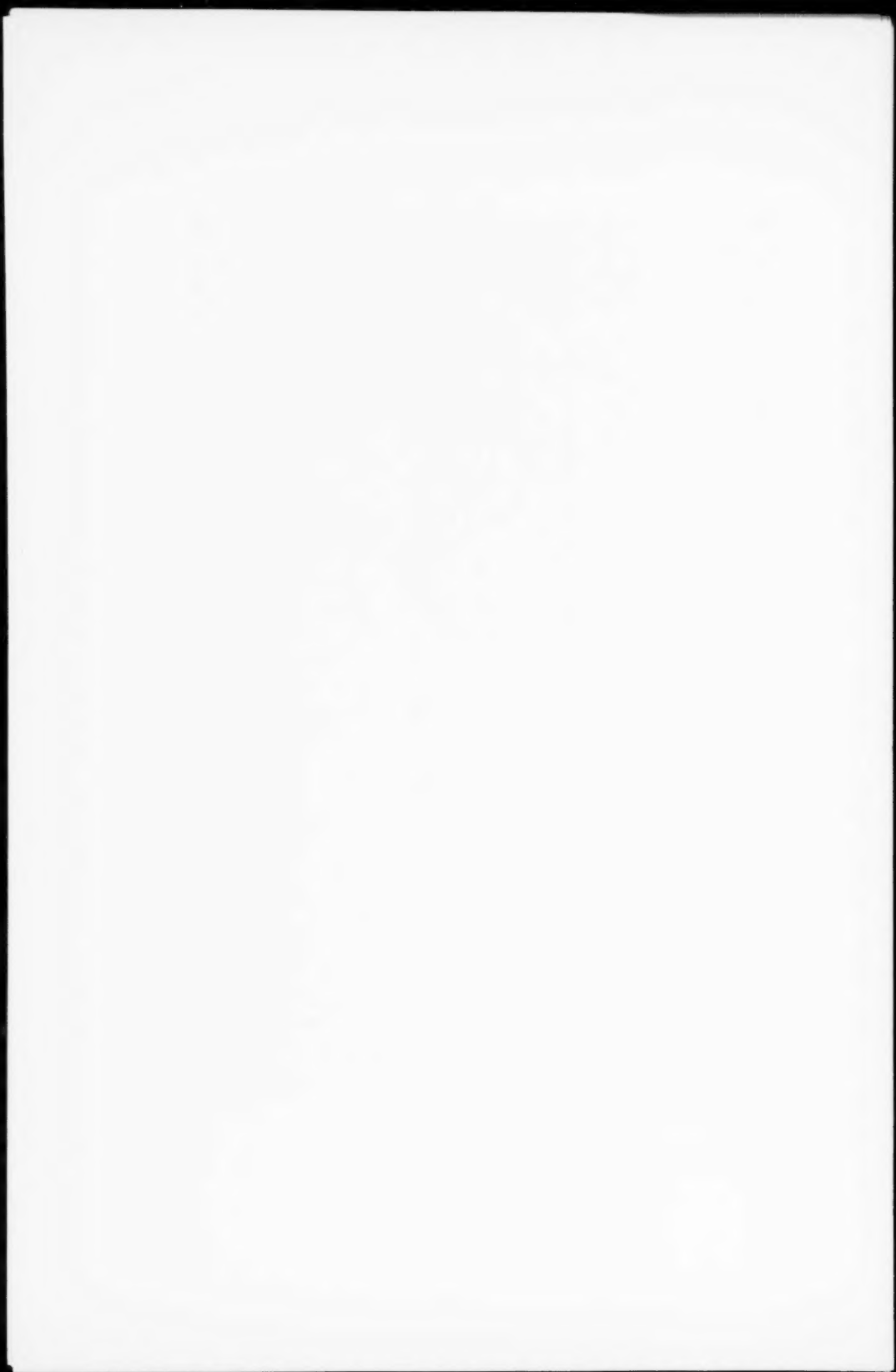
2. Chronic infantile hemiplegia without disorders of behavior and personality.

3. Chronic infantile hemiplegia with disorders of behavior and personality, and without epilepsy. Not all authors agree on this indication. To justify the intervention, it is necessary to have an EEG revealing focal activities over the affected side (even though there are no clinically evident epileptic attacks). The intellectual level must be good and the behavioral problem very severe.

4. Hemiplegia with mental retardation, and with no epilepsy and no character disorder. This combination is hardly regarded as an operative indication.



Figure 1.



## OPERATIVE TECHNIQUE

The intervention consists of the removal of one entire cerebral hemisphere through a large fronto-temporo-parieto-occipital bone flap, under general anesthesia.

The excision of the hemisphere is done after all the parasagittal bridging veins have been cauterized and severed and after occlusion by means of silver clips of the middle, anterior and posterior cerebral arteries (Figure 1) has been carried out. The clips are applied on the anterior cerebral artery at a point past the anterior communicating artery, on the middle cerebral artery at a point 1 cm. distal to the bifurcation, and on the posterior cerebral artery at a point past the origin of the branches supplying the brain stem.

The hemisphere is removed in one or more pieces. The excision line cuts through the corpus callosum and deepens along the outer margin of the thalamus (Laine), leaving out all the basal ganglia but the thalamus; along the outer margin of the caudate nucleus (Gros), leaving out only the putamen; or along the outer margin of the capsula extrema (Feld), with sparing of the occipital cortex. The last procedure is actually a cortectomy rather than hemispherectomy.

## RESULTS

The results of the hemispherectomy are to be considered separately for each symptom and sign.

*Infantile Hemiplegia.* The diseased hemisphere in a case of total paralysis has practically no function. Consequently there is no loss of motor power at any time postoperatively. On the contrary, the diseased hemisphere in a case of infantile hemiparesis exerts some control on the motility of the opposite side of the body. Consequently, postoperatively, for a period between six and 10 days, there is a more marked loss of motor power than there was pre-operatively.

The control of the paralyzed limbs is actually exercised by the ipsilateral (normal) hemisphere. The more marked the degree of disease and functional exclusion of the affected hemisphere, the more developed will be the ability of the normal hemisphere to control the motor activity of both sides of the body. In fact, when the upper and lower limb are not equally affected on the same side, the one which recovers faster postoperatively is the one that was more affected pre-operatively.

It would seem that the structures (thalamus, caudate nucleus, globus pallidus) not removed with the hemisphere play little role in the mechanism of recovery. Good results have, in fact, been achieved with the different operative techniques.

In many cases, motor power in the affected limbs improves after hemispherectomy. This occurs particularly in cases of total paralysis submitted to operative intervention in early age. To explain the fact, it has been assumed that the diseased hemisphere, while not playing a physiological role of its own, inhibits the opposite (normal) one and prevents it from developing a vicarious role.

The theory fits well in the case of a speech defect which improves when a left hemispherectomy is performed on a right-handed subject, before the potentialities of the normal hemisphere's development have exhausted themselves.

Spasticity, or increased resistance to passive stretching, diminishes after hemispherectomy. In this diminution in muscular tone, it is admitted by some authors that the basal ganglia may play a role. According to Penfield, the cortical scars stimulate the reticular facilitatory system.

*Epilepsy.* Following the operation, in a good percentage of cases, epileptic attacks no longer occur. In other cases, there is an improvement; that is, the frequency and the severity of the seizures decrease. In a smaller percentage, no modifications of the seizure pattern are noticed postoperatively.

The result can be anticipated, to a certain extent, by the pneumoencephalographic examination. In fact, it would seem that a satisfactory suppression of the epileptic seizures is conditioned by the unilaterality of the pathological changes.

The electro-encephalographic tests do not always show lateralization of epileptogenic activity, since abnormal electrical activity may be detected over the nondiseased hemisphere, even when the anatomical condition of that hemisphere is normal. It is important to point out that such contralateral (to the affected hemisphere) EEG abnormalities disappear after the removal of the diseased hemisphere. The fact leads some authors to think that their origin is in the diseased hemisphere and that they simply spread to the other side; others think that the abnormal hemisphere exerts a "driving force" on the normal one and that this force recedes after hemispherectomy.

In cases in which the seizures persist, their characteristics remain the same, in the sense that they still consist of tonic phases followed by generalized clonic movements.

Anti-epileptic medication is omitted as a rule when no seizures are recorded for some time postoperatively.

*Mental Retardation.* Only rarely has there been a report in the literature of improvement in the intellectual level of a patient after hemispherectomy. If an epileptic problem has been solved and it has been possible to discontinue anti-epileptic medication, some improvement may be noticed.

*Behavior and Personality Disorders.* Behavior and personality difficulties are subject to clear improvement after hemispherectomy. Explanations are only tentative. The possibilities suggested so far are the following: The hemispherectomy acts like a topec-tomy and reduces the emotional reactivity of the patient; aggressiveness is related to an epileptic condition and is to be regarded as an epileptic equivalent and the result of epileptic degeneration; the personality disorder is due to a neurotic attitude of the patient, who suffers from a feeling of inferiority.

A consideration of the results in general reveals: (1.) No relationship exists between the extent of the excision and the result, except for the hemianopia which follows removal of the occipital lobe. (2.) The results are better in those subjects who suffered their brain damage early in life; it is not important when the intervention is carried out. (3.) The removal of brain lesions due to birth trauma or postnatal trauma offers better results than follow removal of lesions due to encephalitic processes. (4.) The embryogenetic type of lesions predisposes to worse results than lesions occurring after birth.

#### PERSONAL EXPERIENCES

The writers' experience—at Central Islip (N.Y.) State Hospital—concerns nine cases. The pre-operative work-up consisted of: (a) careful consideration of all anamnestic data; (b) accurate study of the type and rate of epileptic seizures; (c) thorough neurological examination; (d) psychometric testing; (e) pneumo-encephalogram; (f) carotid angiogram; (g) electro-encephalogram; and (h) medication trial.

Of 16 patients considered for hemispherectomy, seven were rejected on the grounds that their symptoms were not too well later-

alized. Some patients evidenced paraparesis; others showed pronounced EEG abnormalities on the side opposite to the one proposed for operation. The histories in certain cases, indicated that the brain damage had occurred late in life.

In the nine cases chosen for intervention, the indications were varied. Epilepsy and personality disorders were recognized as the symptoms which can best motivate the procedure.

The operative technique used is in many ways similar to the one adopted elsewhere. To avoid a disfiguring scar, a modified version is employed of the incision which is commonly preferred for the surgical approach to the pituitary gland. It extends from the forehead along the midline to a point 3 cm. above the external occipital protuberance, curving laterally to reach the posterior temporal area. Six burr holes are sufficient to turn down a large fronto-parieto-occipito-temporal flap. The arteries are occluded before the veins, to obtain some degree of diminution of the volume of the hemisphere. Clips are applied on all three major arterial vessels; middle cerebral, anterior cerebral and posterior cerebral. In order to observe the line of excision better, the hemisphere is removed in two pieces. The caudate nucleus was removed completely in all but one of the writers' cases.

The postoperative course was smooth in some of the writers' cases, stormy in others. However, the facts that each patient withstood the procedure well, and that the patients reacted quickly after the intervention, were impressive. Sedation was given to combat agitation and excessive motor activity. Every patient regained consciousness within two hours after the operation. In this series, there was only one death. This occurred on the eleventh postoperative day and was caused by multiple pulmonary emboli from a phlebothrombosis of the left leg. Up until the fifth postoperative day, the patient had had a satisfactory course. He remained conscious until two hours before dying.

The following case is the best illustration in the series of the type of favorable results which one can achieve with hemispherectomy.

#### *Illustrative Case*

Albert, a 10-year-old boy, was admitted to Central Islip State Hospital on a transfer from Craig Colony on August 13, 1956; he had been admitted to Craig Colony at the age of four for intractable epilepsy. His family history revealed nothing significant.

The patient had been delivered naturally. Teething and other physiological functions occurred in a normal way. The first epileptic seizure took place when Albert was two. At the same time, according to the patient's history, he became paralyzed on the left side. The second attack followed, five weeks later. From then on, the epileptic seizures became more severe, and there were as many as four daily, always of the grand mal and petit mal type. The paralysis remained unchanged; but the patient was right-handed and could partly take care of himself. When he was admitted to Craig Colony, aged four, he showed a mental age of two, and was classified as an imbecile.

Later, Albert became hyperactive and aggressive, and molested other patients. He also injured himself frequently. He was put on thorazine, 50 mg., b.i.d., and serpasil, 1 mg. Both drugs had to be discontinued because they made the boy very sleepy.

In 1955, the patient suffered 40 grand mal seizures and three petit mal attacks. During the first eight months of 1956, he had 51 grand mal attacks. At Central Islip, 20 seizures were recorded in about four weeks.

The boy's anti-epileptic medication consisted of phenobarbital, grs.  $1\frac{1}{2}$ , t.i.d., and dilantin, grs.  $1\frac{1}{2}$ , once a day.

*The Neurological Examination* revealed: (1) An asymmetrical skull, the left side flattened, especially in the frontal region. (2) Asymmetry of the chest, the left hemithorax smaller than the right. (3) The left arm shorter and thinner than the right; the left foot internally rotated, the knee slightly flexed. (4) A hemiplegic gait with circumduction of the left leg at the hip joint and shuffling of the foot. (5) Motor power over the left side of the body greatly diminished; fine distal movements lost. (6) Increased resistance to passive stretching of the left upper and lower limbs; contractures, with flexion at the elbow of 90 degrees and flexion at the wrist of 45 degrees. (7) Increased deep reflexes on the left; absence of abdominal and cremasteric reflexes; no pathological reflexes (Hoffman rapidly disappearing). (8) No gross sensory deficits (testing cannot be accurate).

*The Psychometric Testing* indicated a mental age of two years and nine months with an IQ of 29.

*The EEG Findings* were: absence of alpha rhythm, polyrhythmia, continuous on the right side, subcontinuous on the left side,

consisting of waves, 3 to 7 cycles per second in frequency, 15 to 45 microvolts in amplitude, quite altered in morphology—round, sharp, pointed, dicrote or superimposed waves. (Figure 2.) On the left side, sub-alpha patterns appeared occasionally as short bursts of waves, 7 to 8 cps. 10 to 20 mv., rather disrupted in morphology.

*The Pneumo-Encephalogram* revealed a marked dilatation of the right lateral ventricle with a shift of the left lateral ventricle and third ventricle to the right—atrophic shift. (Figure 3.)

*The Carotid Arteriogram* confirmed the shift of the ventricular system by demonstrating a contralateral shift of the anterior cerebral artery.

*Operative Intervention* was carried out on September 24, 1956 according to the technique described in this paper. Striking findings were represented by the presence of several subgaleal and subcutaneous hemorrhages (due to traumata) and by the existence of a marked thickening of the arachnoid which appeared also strongly adherent to the brain. (This is to be interpreted as the result of a meningitic process.)

*The Pathological Examination* of the removed hemisphere demonstrated microgyria and considerable firmness of texture. Marked atrophy, especially in the frontal lobe, was also observed.

*The Microscopic Examination* showed lymphocytic infiltrates in the thickened meninges; atrophy of the cortex, with disorganization of the neuronal arrangement and depopulation of neurons; also considerable perivascular round cell infiltration and diffuse areas of gliosis.

*The Postoperative Psychometric Examination* indicated no marked changes in the intellectual level of the patient. (The test was done on November 20, 1956.) However, it was the impression of all the personnel on the ward that the patient was much more sociable and somewhat brighter.

*The Postoperative Electro-Encephalogram* showed bilateral polyrhythmia consisting of waves, 5 to 15 cps., with an amplitude rarely higher than 10 mv., and a morphology that was still disrupted but much less so than was previously noticed—the shape was now predominantly round. Occasionally, there were bursts of three to six elements of higher voltage (20 to 30 mv.), 5 to 6 cps., regularly round, bilateral but not synchronous. (Figure 4.)

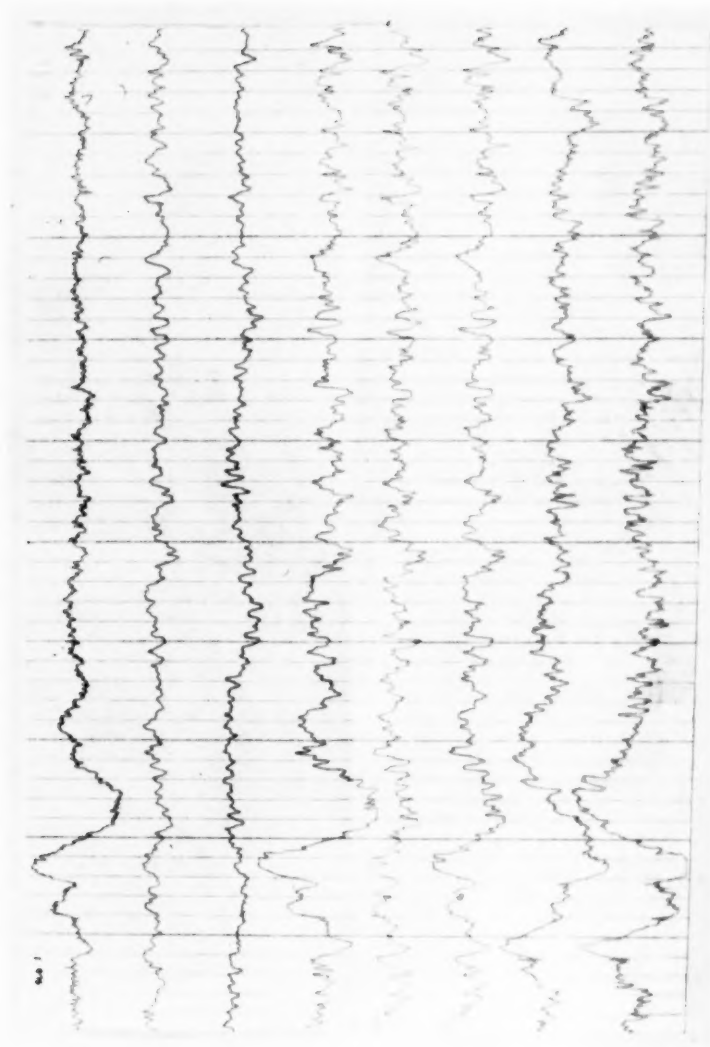


Figure 2.

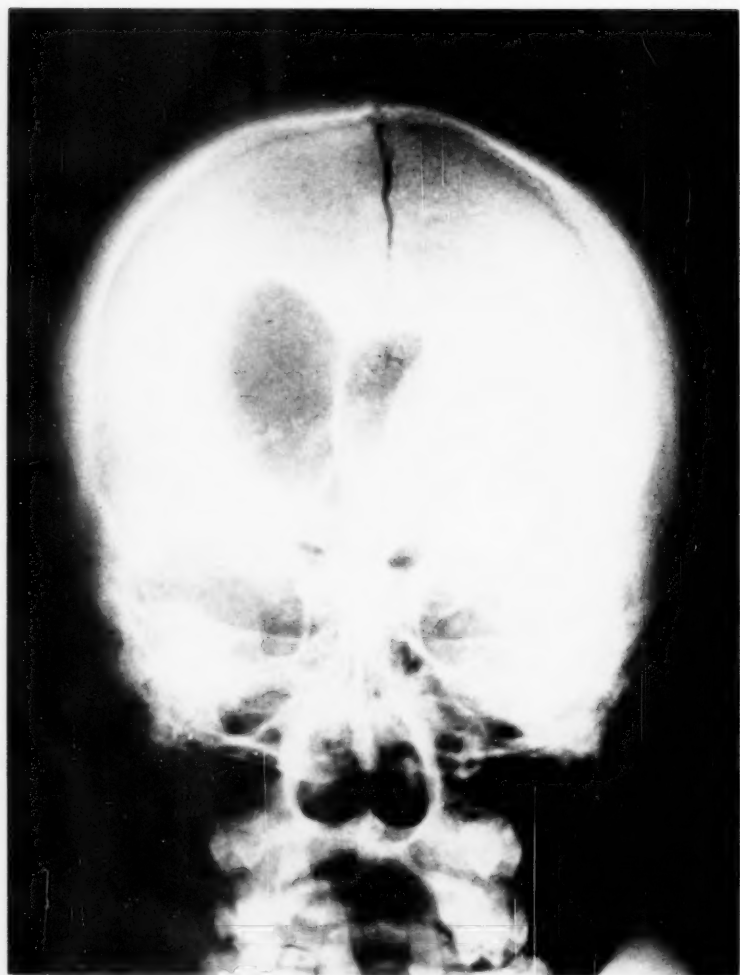


Figure 3.

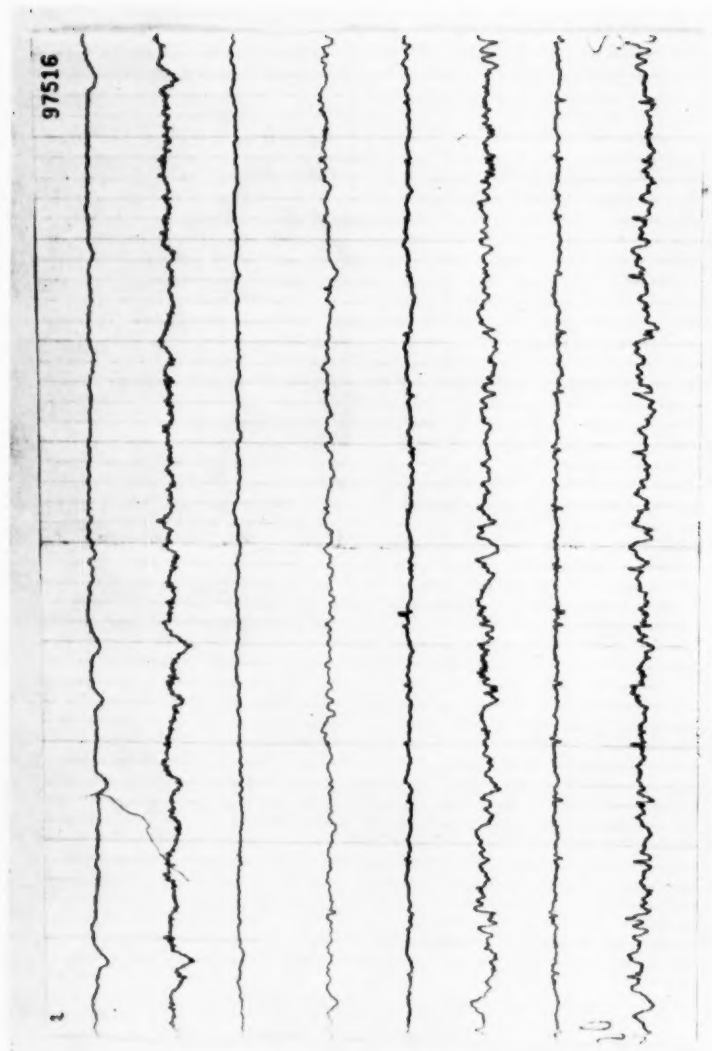
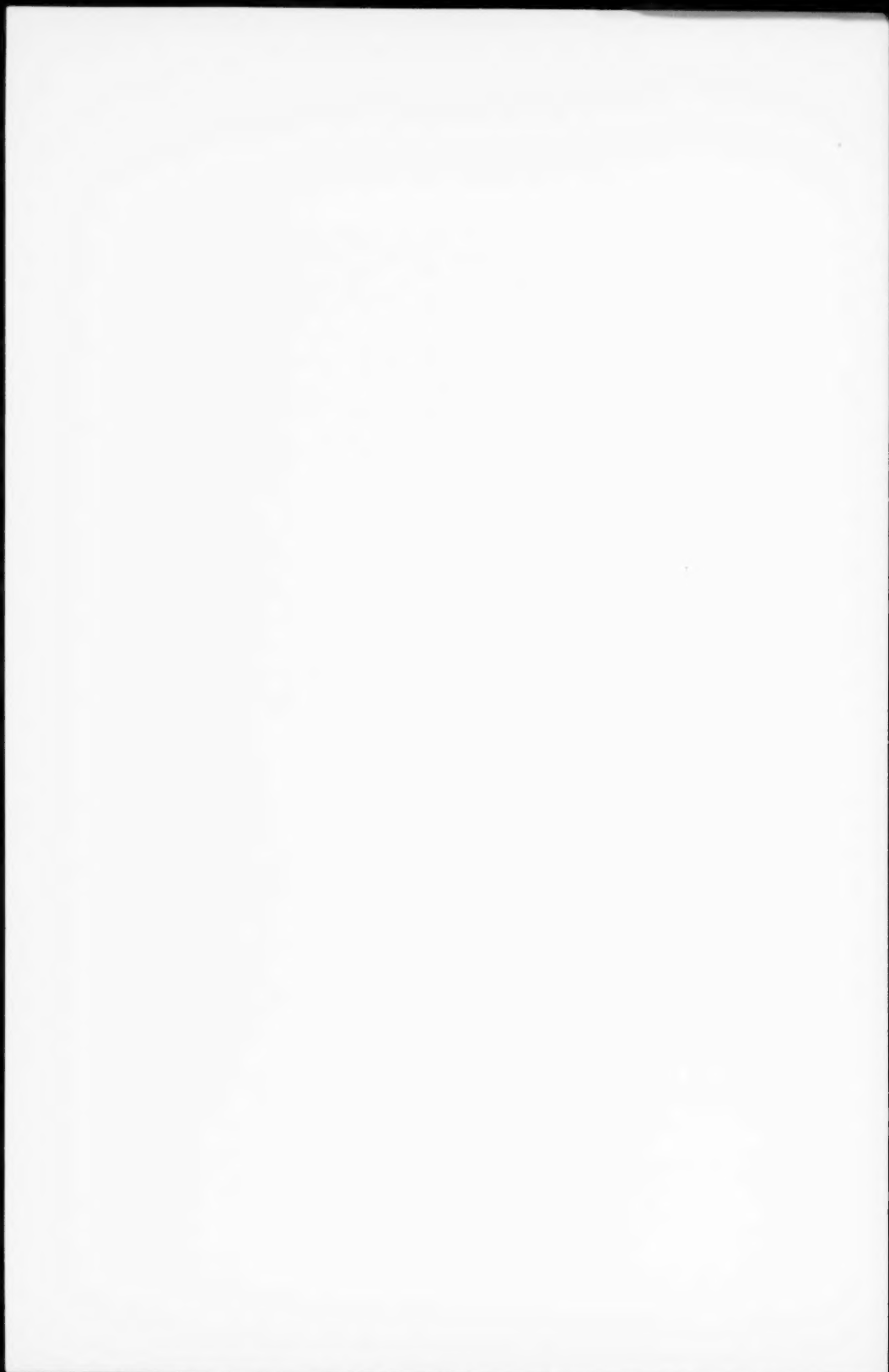


Figure 4.



*Clinical Observations* of the patient included two most impressive facts: The muscular spasticity diminished markedly; no epileptic seizures occurred. As a result of the lessened spasticity, the patient's arm and hand posture have greatly improved, and wider movements are possible. Although the follow-up period is still short, it would seem justified to classify the result as excellent.

*In the Other Cases*, the results were on the average satisfactory.

#### SUMMARY

The indications, the technique and the results of hemispherectomy, as a means of treatment of spastic hemiplegia, epilepsy and behavioral anomaly, are discussed. The authors' experience is based on nine cases. One, reported in full in this paper, illustrates the kind of favorable results which one can achieve by hemispherectomy.

#### ACKNOWLEDGMENT

The EEG tracings were read by V. Conigliaro, M.D., senior psychiatrist, at Central Islip (N.Y.) State Hospital, to whom the authors wish to express their appreciation.

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## MASSIVE CHLORPROMAZINE THERAPY: THE NATURE OF BEHAVIORAL CHANGES\*

BY ROY M. MENDELSON, M.D., ALLEN S. PENMAN, Ph.D. AND  
BURTRUM C. SCHIELE, M.D.

### INTRODUCTION

Although the voluminous literature on chlorpromazine indicates that the drug has favorable effects on the behavior of many psychotic patients, there still remains considerable confusion, contradiction and uncertainty about the details of administration and indications for treatment. In addition, the writers have not felt that there has been an adequately-controlled study of the effect of chlorpromazine on chronic, extremely regressed, schizophrenic patients.

The controlled studies reported have been infrequent and often unclear, and the evaluation of results has been largely subjective; or the measurements have not sampled sufficient areas of functioning to give complete data on the behavioral changes induced by the drug. Since there have been innumerable studies reported, the writers are not going to attempt to summarize them in this paper. The writers also feel that some of the controlled studies, even though carefully carried out, have appeared somewhat artificial as compared to the natural treatment of individual patients. It is the writers' impression, as gained from the literature and from their own experiences, that individual dosages of the drug must be gauged by the results obtained with individual patients. For these reasons, it was aimed to design this study to embody the use of a control group, objective measurements of behavior, and medication prescribed individually, according to the needs of each patient. Since one of the important aspects of treatment is the concurrent environmental or milieu therapy, this was also prescribed individually as far as possible.

### EXPERIMENTAL SUBJECTS AND CONTROLS

This study was conducted at the Veterans Administration Hospital, St. Cloud, Minn., a predominantly neuropsychiatric hospital of 1,379 beds. The population of this hospital is made up largely of chronic mental patients.

Patients who have not been responsive to former types of treat-

\*From the Veterans Administration Hospital, St. Cloud, Minn.

ment, such as electric shock, insulin, lobotomy, total push programs of various kinds, and forms of interpersonal therapy, offer a good test for any new therapeutic procedure. Patients of this type were deliberately selected for the present study, as offering the greatest challenge to the effectiveness of any drug. If chlorpromazine was found to be effective, it would provide at least part of the answer to one of psychiatry's greatest problems.

The experimental pool consisted of 38 chronic schizophrenics who had been hospitalized for an average of six years and whose average duration of illness was slightly over eight years. All patients selected had received extensive treatment. Although many had shown periods of temporary improvement in the past, they had remained chronically ill and had manifested a downhill course during hospitalization. For some time before the study they had failed to show any improvement whatsoever, and had remained on a somewhat stabilized level of adjustment for a median of 40 months. Most of the patients, however, did have histories of having made adequate adjustments in the community for several years before the onset of illness. The 38 patients were split into two samples ( $N=19$  each), which were matched with respect to the following variables: age, length of hospitalization and duration of illness (see Table 1); Minnesota Multiphasic Personality

Table 1. Comparative Characteristics of the Two Patient Samples

	Age*	Duration of Illness (mos.)	Mos. of Total Hospitalization*	Diagnosis					Previous Treatment				
				Paranoid	Catatonic	Mixed	Insulin	ECT	Lobotomy	Chlor.**	Tot. push	Educ. Level (yrs.)	Years Without Change
Drug	32.5	97.3	76.1	11	6	2	12	19	5	6	9	10.6	5.1
N=19	(5.39)	(49.86)	(40.24)										
Placebo	32.3	97.3	70.8	13	4	2	11	19	4	3	9	11.9	4.75
N=19	(5.49)	(38.27)	(37.66)										

\*Mean age. Standard deviations are in parentheses.

\*\*Chlorpromazine previously given in smaller dosages for shorter periods of time.

Inventory profiles (MMPI),<sup>1</sup> (see Figure 1); and a specially constructed behavior rating scale. One sample was arbitrarily designated to receive the drug, the other to receive the placebo. The

mean number of pathological behavior items checked for the drug group was 35.6 with a standard deviation of 12.42, and the mean of the control group was 34.0 with a standard deviation of 14.74.

At the beginning of the study, the patients were characterized by a complete lack of interest in their environment and were either regressed, mute, unresponsive, or hostile and combative. (See Table 2.)

Table 2. Types of Behavior Represented Prior to Study  
(Number of Patients)

GROUP	Assaultive and Destructive	Withdrawn	Negativistic	Feeding Problems	Toilet Problems
Drug . . .	7	9	4	5	2
Placebo .	8	9	4	5	1

#### PURPOSES OF EXPERIMENT AND HYPOTHESES TO BE TESTED

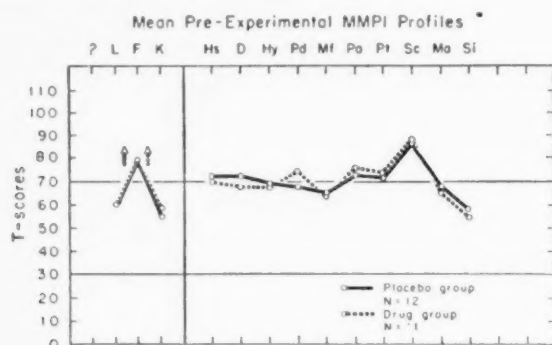
Two questions were raised. First, how effective is chlorpromazine in the treatment of chronic schizophrenics of the type described? Second, what is the best dosage procedure? The writers' impression from a review of the literature was that the "high dose" type of treatment was the most promising and the most logical approach to use in the initial stage of the experiment. The first stage of the experiment is being reported in this paper; the placebo group was treated later with a "low dose" regime, and the results of this second stage are given in another report.\*

Concurrent environmental treatment is and has been a part of the treatment program for all the patients. The present plan embodied some individual milieu prescriptions, with sufficient flexibility to foster any improvement that might occur. It was hypothesized that chlorpromazine alone would be inadequate and that varied and numerous interpersonal contacts and group activities would have to be provided. These activities included adaptive sports, bowling, music, educational therapy, corrective therapy, manual arts therapy, dance instruction, church, library, group discussion and the like. If a medication is effective, it should enable the patients to communicate with others, to participate in activities and to derive sufficient personal satisfaction from these activities so that they would be reluctant to give them up. Stated briefly and formally, the hypotheses were:

\*Pending publication, *PSYCHIATRIC QUARTERLY*.

*Hypothesis 1:* Chlorpromazine will have an effect on patients which will result in clinical and behavioral improvement beyond that which can be attributed to suggestion, increased attention, or changes in ward routine.

*Hypothesis 2:* The placebo group will show some improvement from the increased activities, increased interpersonal contacts and the effects of getting some medication, but the improvement will be less than that shown by the drug group.



\* L, F and K are validity indicators. The clinical scales were constructed to measure resemblances to the following clinical groups: Hs-hypochondriasis, D-depression, Hy-hysteria, Pd-psychopathic deviate, Mf-masculinity or femininity of interests, Pa-paranoid state, Pt-psychasthenia, Sc-schizophrenia, Ma-maniac state, Si-social introversion.

Figure 1.

Only the psychiatrist in direct charge of the ward, the senior consultant and the psychologist who matched the two groups were aware of which patients were getting chlorpromazine and which ones were receiving placebos. The ward psychiatrist was informed so that dosage might be individually prescribed and any complications dealt with promptly and properly. All of the observations of the patients, with the exception of the Wittenborn Scale ratings and the clinical evaluations, were made by members of the staff who did not know which patients were controls and which were receiving the drug.

#### PROGRAM OF STUDY

The entire project may be divided into the following five phases:

1. A standardization period of four weeks, during which the patients became accustomed to the ward and to the group activi-

ties. This was to establish base lines for both behavioral and physiological measurements.

2. A period of two weeks during which both groups were placed on placebos to evaluate the effect of receiving "some kind of pill."

3. An intensive treatment period of three months. The plan was to individualize the drug schedule so as to alter the dosage according to each patient's response. Each patient was begun on 400 mg. of chlorpromazine. The dosage pattern involved increasing the amount by 200 mg. a day until a maximum dose was reached (not over 3,000 mg.). Each patient would continue on his maximum dose for three weeks, at which time the drug would be reduced (by decreases of 200 mg. each) to a maintenance level. The *maximum dose* was defined as that amount which led either to clear signs of improvement, such as increased communication, less overt indications of psychotic behavior, and increased participation in activities, or to the development of physiological complications necessitating a lesser amount. The *maintenance dose* was defined as the smallest amount (at least 200 mg.) to be followed by continuation of clinical improvement. It must be emphasized that the dosage was varied according to each patient's response. Only 14 patients reached the maximum dose of 3,000 mg. a day. The other five reached maxima of 2,400 mg., and each of these had his dosage lowered by 200 or 400 mg., after one or two days. The maintenance dosage ranged from 200 to 800 mg., except for two patients who were maintained on 1,200 mg. a day. Thus, if—in reducing dosage to seek a "maintenance" level—improvement was not maintained, the dosage was again elevated.

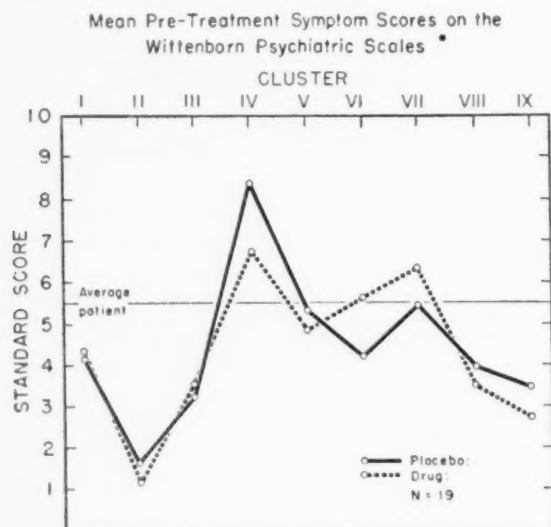
4. Follow-up period: At the end of the three-month intensive treatment period, the final objective psychological ratings were made. Following these ratings, the writers' approach to the maintenance treatment of the patients continued in the pattern already described. Each patient in the drug group had a "partner" in the placebo group who received the same number of placebo tablets as did his partner in the drug group. This was done to minimize the identification of drug patients. Whenever the drug patient's dosage was changed, the dosage for his partner in the placebo group was changed simultaneously.

5. Following the postexperimental evaluations and retesting, the placebo group was placed on a "low dose" chlorpromazine regimen.

This change marks the end of the controlled first half of the experiment.

#### METHODS OF EVALUATION

In addition to behavior rating scales and the MMPI, which were used as matching variables, the ward psychiatrist completed a Wittenborn Rating Scale<sup>2,3</sup> for each of the 38 patients. For this, he reviewed hospital records and conducted intensive clinical examinations. It turned out that these psychiatric ratings, which were made without knowledge of which group a patient would be in, showed the two groups to be well matched on the items concerned. (See Figure 2.)



\* The symptom clusters have been identified as follows: I—Acute Anxiety; II—Conversion Hysteria; III—Manic State; IV—Depressed State; V—Schizophrenic Excitement; VI—Paranoid Condition; VII—Paranoid Schizophrenia; VIII—Hebephrenic Schizophrenia; and IX—Phobic Compulsion.

Figure 2.

From the beginning of the pre-experiment phase until the end of the experiment period, each patient was rated every four weeks by two psychiatric aides on a behavior rating scale. Blood pressures were taken weekly, and weight was recorded monthly.

Before constructing the behavioral rating scale to be used for evaluating the effectiveness of the drug, the chief clinical psy-

chologist made a survey of 27 reported chlorpromazine studies, and tabulated the recorded behavioral changes.\* This was done in order to include items in the scale which corresponded with behavior presumably changed by the use of the drug. (See Table 3.) Reported clinical evaluations of the effects of the drug vary so widely with respect to induced behavioral changes that it was felt necessary to provide a means to evaluate the results more objectively by including in the scale as many manifest behavior items as possible. It was considered important to design an instrument specifically intended to measure the effects of the drug, rather than to use one of the already existing behavior rating scales. For this reason, the scale included items which would measure all of

Table 3. Behavioral Changes Attributed to Chlorpromazine in 27 Reported Studies

Behavior Changed*	Number of Studies in Which Change was Reported
1. Delusions .....	8
2. Hallucinations .....	6
3. Insight into 1. and 2. ....	2
4. Inappropriate affect .....	1
5. Overt hostility to staff or hospital .....	6
6. Verbal communication .....	6
7. Assaultiveness .....	7
8. Incontinence .....	2
9. Denudativeness .....	1
10. Behavior requiring restraints and hydrotherapy .....	9
11. Excitement and disturbed behavior .....	19
12. Muteness .....	1
13. Neatness .....	4
14. Agitation and anxiety .....	17
15. Obsessions and compulsions .....	3
16. Physiological complaints .....	3
17. Receptiveness to psychotherapy .....	5
18. Interest in activities .....	4
19. Co-operation .....	3
20. Fear and panic .....	4
21. Suspicion .....	1
22. Withdrawal .....	7
23. Feeding problems .....	9
24. Negativism .....	2
25. Toilet problems .....	1
26. Sleeping .....	3
27. Destructiveness .....	3

\*Changed or altered in a favorable direction by the use of the drug.

\*This aspect of the study followed closely the suggestions of William Schofield, Ph.D., division of clinical psychology, University of Minnesota, senior psychological consultant to the St. Cloud Veterans Administration Hospital.

the behavioral changes reported in Table 3. In addition, it was felt that it would be desirable to include other items in the final scale, because it is not possible as yet to predict just what behavior is affected by chlorpromazine, or to what extent certain types of behavior are affected.

Several training sessions were held with the psychiatric aides who were to use the scale, and they practised with it by rating patients who were not to be included in the study. Several revisions of the scale were made before its final form. This scale will be referred to as the Manifest Behavior Scale in the rest of this paper.\* Since the same two psychiatric aides rated each patient in the study, the mean of the two raters for each item on the scale was used in recording the behavior ratings for each patient. Interrater reliability was .92, and the percentage of agreement between raters was 83. The mean of all of the patients' scores for each behavior item on the scale was then recorded as the group score for that item for comparison between groups. This allowed for a comparison between groups on each of the various kinds of behavior rated, as well as between groups with respect to over-all behavior. The scores recorded are given in terms of the number of items out of a possible 90 which were answered in the direction of pathology. A decrease in score indicates improvement.

## RESULTS

### 1. *Clinical Results*

#### A. *Standardization.* (four weeks)

During the four weeks of standardization, the patients would not assist in ward housekeeping, and, for the first two weeks, there was an average of three fights a day. There was very little patient participation in the adjunctive therapies, and, as a group, the patients exhibited a rather passive, indifferent attitude toward them. There was no behavior that could be described as communicative or as social interaction between patients or between patients and personnel.

#### B. *Placebo Period.* (two weeks)

The most significant observation on both groups during the two weeks on placebos was of increased co-operation in ward work and ward activities. No changes were observed with respect to individ-

\*Copies of this scale may be obtained by writing to the chief psychologist, Veterans Administration Hospital, St. Cloud, Minnesota.

ual behavior, but both groups adjusted quickly to the routine of taking pills, and there were only two patients of the 38 who refused to take them orally. Those two patients received their dosages intramuscularly. Several of the patients who had had chlorpromazine previously complained of being tired, although their fatigue was not observed by the personnel.

*C. Intensive Treatment Period. (three months)*

Only the ward physician knew the day chlorpromazine was begun, but several other members of the ward personnel were immediately aware that something was different. Thirteen of the patients tended to fall asleep while at activities; only 11 of these were receiving chlorpromazine. During the first two weeks, most of the drug patients suffered extreme lethargy and drowsiness. In spite of this, the activity schedule was maintained as planned, even though many of the patients had to be physically supported while going to and from activities. There was a general reduction of the activity level in the ward. Many of the patients asked to go to bed early, including several in the placebo group, and it was only with effort that the personnel were able to keep some patients awake during activities.

After the patients had been on maximum dosage for a few days, the drug group appeared more alert and responsive than before medication. They began to request ward work, showed increased participation in activities, began reading newspapers and magazines, and in general became a quieter group, with a complete absence of assaultive behavior. Assaultive behavior involved only patients in the placebo group.

During the third week, eight of the drug patients sought out the ward physician, complaining of feeling "different" and of being frightened and uneasy. They demonstrated tremulousness, rapid pulse, profuse diaphoresis and dilated pupils. Believing that these patients who had been in a rut so long were now reacting with anxiety to the changes that were taking place, the physician gave firm and repeated reassurance that the program was to help the patients feel better and not to force them into making changes. Shortly thereafter, all of the patients settled down and began to show signs of improvement in behavior.

During the fourth week, small groups of patients were seen to be talking to each other for the first time. More spontaneous contacts were made with the doctor, the adjunctive therapists, and the ward personnel. Those showing the changes were drug patients; and, while they retained their delusional ideas and hallucinations, speech and behavior were better integrated.

Although ward housekeeping had previously been a problem, the ward personnel now had to search for jobs to fulfill the requests of the drug patients for ward work. For the first time, it was possible to have dances on the ward, with the patients in the drug group participating actively and apparently deriving some enjoyment.

Some of the patients who had shown no discernible improvement while on maximum dosage began to show favorable response when the dosage was reduced. Toxic signs, such as wooden facial expressions, slurred speech, unsteady gait and some degree of apathy, seemed to mask the improvement which became evident immediately when the toxic signs disappeared.

By the twelfth week, when all drug patients were on maintenance doses, the change in the ward social structure was striking, in spite of the fact that the placebo patients continued with much the same behavioral pattern as previously. There was a friendly, pleasant atmosphere on the ward, with patients being much more co-operative than formerly, and engaging in many more activities. The patients who had improved began writing letters to their families, and the families told the hospital personnel of their amazement at the changes in the patients when they visited them. Family members began to visit the patients more often than they had in the past. Ten of the 19 patients in the drug group were able to visit successfully outside.

Of the placebo patients, one was dropped from the study, because he had received chlorpromazine through error. Another showed improvement by becoming more friendly, relaxed and co-operative. The patient himself felt that he had benefited from the attention given him, the firm controls, and the activities.

There were four other placebo patients who became worse, three of them being more confused and hallucinative than before, and

having frequent outbursts. The fourth showed an intensification of his seclusive and withdrawn behavior. The other 13 placebo patients showed no change whatsoever.

*D. Follow-Up Period. (six months)*

Of the drug group, one patient was dropped from the program because of a severe skin reaction.

At the end of the follow-up period, three patients were at home and making good adjustments. All three had obtained employment, were continuing their medication, and were being seen by their local physicians or in an out-patient department.

Three patients were on an open ward where all three had been taking passes in their own custody. They had been home for as long as a week at a time, had adjusted satisfactorily; and their families were beginning to make plans with them for their eventual return home. All these patients had been making excellent open ward adjustments and were thinking in terms of leaving the hospital in a short time.

Four patients were on a different ward than formerly—one which offers more privileges and is less structured. This is a ward in which the patients begin to assume more and more responsibility for their own behavior, and where they go on short passes in their own custody—slowly and gradually working toward the point of rehabilitating themselves. All four drug patients were making excellent adjustments there.

Two of the patients remained on the original ward and still required continued support and reassurance, were extremely unsure of themselves, and were unable to function well without supervision. However, they had been able successfully to go on pass, home with their families, for short periods.

Two patients who had previously been extremely assaultive and who refused to participate in any activity had also remained on the original ward but were entering into the activity program. They continued to be markedly disorganized, but there was improvement in their behavioral adjustment.

Two others on the same ward showed no discernible change and no improvement from their pre-treatment patterns of adjustment.

Still two more were on another closed ward but had improved to the extent that it was possible to start a group with them that was oriented toward foster home placement. These patients were still unable to function in a less structured environment, but were attempting to deal more realistically with their feelings of insecurity and their plans for the future.

One of the most encouraging results of the study has been that most of the drug patients have continued to improve beyond what has been reported in the controlled portion of the study.

## 2. Psychometric Data and Objective Measurements.

### A. Wittenborn Rating Scales.

As indicated in Figure 3, the ward psychiatrist's ratings of the placebo group on the Wittenborn scales showed these patients to be unchanged on six of the nine scales, and with reliably poorer mean ratings on the manic and phobic compulsive clusters. By contrast, the drug group (see Figure 4) showed no change on the depressed and phobic compulsive clusters, a reliable increase in hysteroid symptoms and a reliable decrease of symptoms in the remaining six clusters.

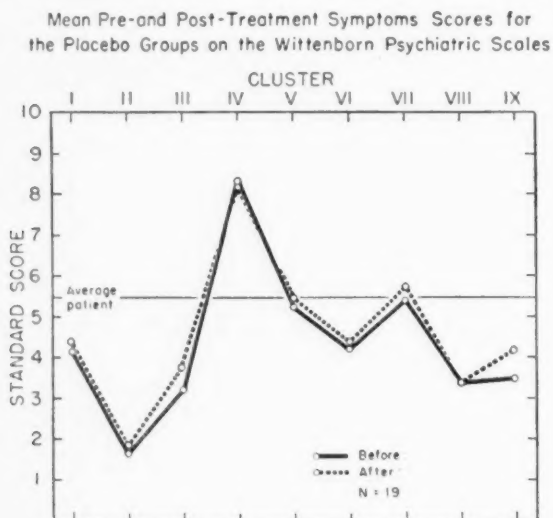


Figure 3.

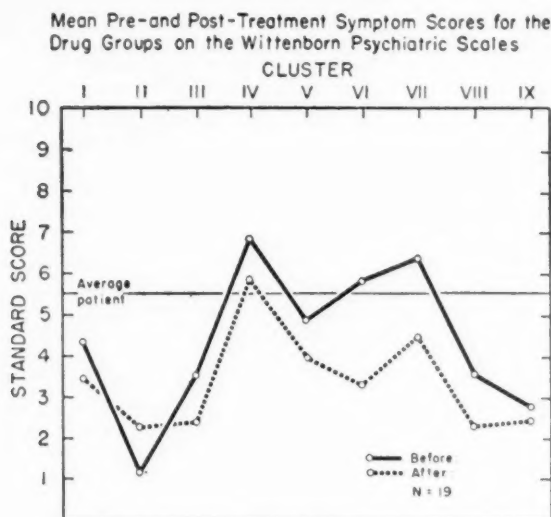


Figure 4.

### B. Minnesota Multiphasic Personality Inventory.

There are no reliable changes in the scores of the drug group on any of the MMPI scales. (See Figure 5.) Retest scores of the placebo group were found to be reliably higher (at the 5 per cent level) on the F, Pd, and Sc scales. (See Figure 6.)

### C. Manifest Behavior Scale.

Figure 7 shows the mean number of symptoms on the Manifest Behavior Scale, recorded for the placebo and drug subjects at each of three points in the experimental period.

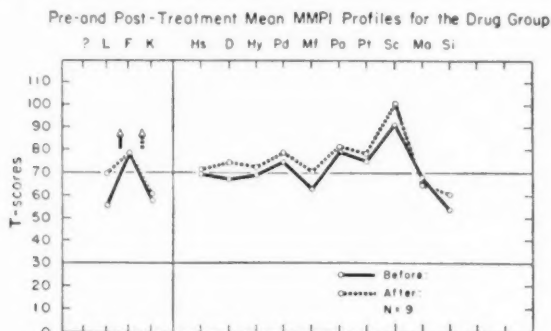


Figure 5.

Pre- and Post-Treatment Mean MMPI Profiles of Placebo Patients

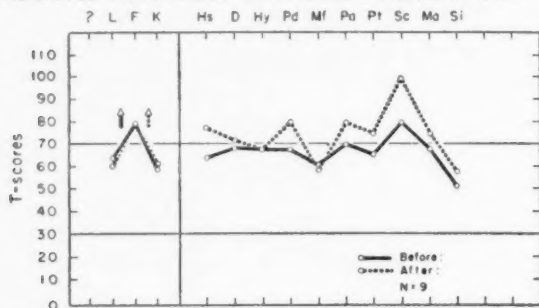
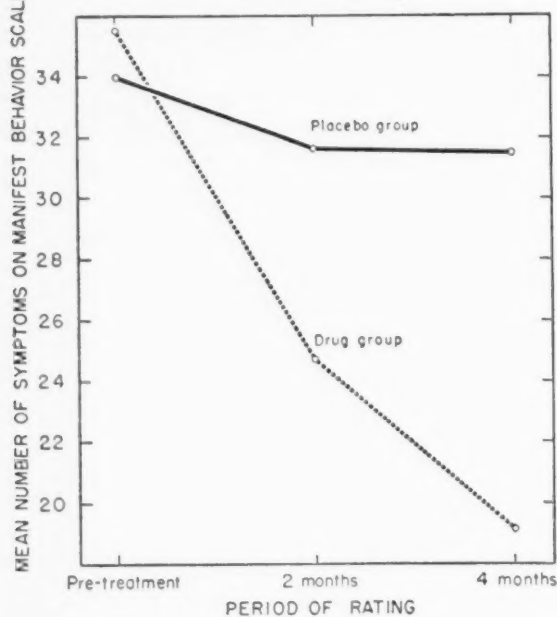


Figure 6.

Table 4 reports the items on the authors' Manifest Behavior Scale which changed significantly in the drug group. Unless otherwise noted, all of the changes were in a favorable direction.

Mean Ratings on the Manifest Behavior Scale at Three Periods of the Study \*



\* Higher scores indicate greater pathology

Figure 7.

It will be noted that the drug group improved significantly on 25 of the possible 90 items of the scale and changed in the pathological direction on only one item (Item 62). The placebo group remained unchanged on all items with the exception of one (Item 18), on which the members were rated as showing significantly more frequent changes in mood than they had shown previously.

Table 4. Manifest Behavior Scale Items Showing Reliable Improvement in the Drug Group

Item Number on Scale	Statement
2.	Does he talk to, or answer, what might be hallucinations?
4.	Does the patient talk to himself or to no one in particular?
7.	Sometimes swears at the aides or other personnel.
8.	Is usually irritable or grouchy.
9.	Frequently expresses ill-will, bitterness, or hate toward other people or family.
10.*	Often swears, curses or uses obscene language.
11.	Frequently has tantrums.
13.	Becomes angry when reasonable requests are made of him.
14.	Becomes easily upset when things don't suit him.
17.*	Gets excited and demanding if he doesn't get what he wants right away.
18.*	Has frequent changes in mood.
19.*	Constantly moves about, and does not stay quiet when asked to do so.
27.	Is irritated if asked a question.
29.	His talk usually makes sense.
30.	You can hold his attention.
32.	Repents words and phrases in a meaningless and mechanical way.
36.	Will always reply if you make some remark to him.
38.	Moves away when spoken to.
41.*	Ignores all activities around him.
47.*	Combs his hair.
54.	Shows constant tension (fidgeting, tremors, muscle twitching, excessive sweating, etc.).
56.*	Appears apprehensive about something happening to him.
62.*†	Usually looks tired and worn out.
66.	Usually does what is expected of him without urging, coaxing or special handling.
72.	Takes part in recreation and ward parties.

\*Significant at the .05 level. All other items were reliably improved at the .01 level.

†Changed in the poor direction.

An item analysis of the changes found in the drug group might be summarized as follows. The patients in the drug group showed no basic change with respect to having hallucinations or delusions, but there was a significant change in their reactions to them. There was a reduction in hostility to a significant degree. There was a marked reduction in mood swings and less "pacing" or moving

about and being noisy while on the ward. The patients in the drug group still did not talk about sports or other topics with aides or nurses, did not initiate conversation, did not talk about their families or *volunteer* other information about themselves, did not talk over happenings on the ward with the aides, still seldom said more than three or four words at a time, tended to stay by themselves, did not follow events in the daily papers or read newspapers or magazines, had no close friends on the ward, and did not know the names of the aides.

However, significant changes were found with respect to the following items: They were no longer irritated when asked questions; their conversations usually made sense; one could hold their attention; they no longer repeated words or phrases in a meaningless or mechanical way; they responded to remarks, paid attention to activities around them, took part in recreation and ward parties, played cards, took part in activities themselves, and no longer moved away when personnel members spoke to them. There appeared to be significant improvement with respect to tension and apprehension, but as rated by the observers, they appeared "unhappy." They were also rated as appearing significantly more tired and worn out.

Very little change was noted with respect to personal care, as the personnel still had difficulty in bathing the patients; the patients' clothes were still soiled; patients did not evidence pride in appearance by requesting clean clothes, and were still rated as being "sloppy." The only change noted in personal appearance was that they did comb their hair. Most of the drug patients still did not ask for work; they required supervision on the job, were somewhat variable with respect to work (some days they were willing to work and other days they were not), and they still would not go on work details if they felt they were being ordered to do so. They were significantly more co-operative in that they did not require urging, coaxing or special handling to get them to do what was expected of them, and they could be reasoned with if they made unreasonable requests of the personnel. There were fewer violations of ward rules and regulations, and the patients appeared to be motivated to abide by the rules set up on the ward.

If the behavior rating scales are examined individually, and the patients rated in terms of "improved," "unchanged," or

"worse," the following results appear. In the placebo group three were improved, 13 were unchanged and three were worse. In the drug group, 14 were improved, four unchanged and one worse.

A negative relationship was found at the .05 level of significance between degree of improvement and chronicity. No relationship was found between degree of improvement and age.

3. *Side Reactions.* (These occurred exclusively in the drug patients unless otherwise stated.)

*A. Lethargy and Drowsiness.*

For a period of approximately two weeks, the patients were extremely drowsy, even to the point of requiring actual physical support in order to attend activities. They gradually became more alert and responsive, regardless of the fact that with some the dosage was kept at the same level, and with others the dosage was increased.

*B. White Blood Counts.*

At some time during the course of the treatment, 17 of the drug patients had white blood counts ranging from 17,000 to 40,000. The differential count was normal, and there was no clinical sign of infection. There was individual variation from week to week, and 10 of the patients on placebos were found to have the same response. There were no instances of lower than normal white counts.

*C. Gastro-intestinal Disturbances.*

Two of the patients developed nausea, vomiting and epigastric pain. These reactions were not affected by the manipulation of dosage and did not disappear until a maintenance level of 200 mg. a day was reached five months later.

*D. Skin Reactions.*

Five patients developed generalized maculopapulovesicular eruptions accompanied by itching. Though the chlorpromazine was continued, these symptoms cleared up in four of these patients; they received benadryl, 50 mg., t.i.d. The fifth patient, despite trials with varied medicines, developed a fulminating dermatitis with edema and a generalized toxic reaction. This was the only patient in whom it was necessary to discontinue the drug. It is perhaps significant that this patient had a history of allergic skin reactions on several occasions. Prior to treatment he was disheveled, delusional, hallucinative, reactive, destructive, and

confused. With chlorpromazine he became friendly, pleasant and co-operative, participated in activities, and communicated in an integrated fashion. Unfortunately, he quickly regressed to his pre-treatment level when medication was discontinued.

The drug patients showed heightened sensitivity to sunlight. For example, shortly after the controlled part of the study had been completed, both groups went for a walk on a sunny day. The chlorpromazine patients could easily be distinguished from the placebo group by the greater degree of their sunburns.

#### *E. Extrapyramidal Syndrome.*

Twelve of the 19 patients developed rigidity, drooling, trembling, masked faces and pill-rolling tremor. In all cases, these symptoms were greatly relieved by the administration of methanesulfonate ("Cogentin"), and they disappeared completely with lower maintenance levels.

#### *F. Toxic Signs.*

Between the range of 1,600 to 3,000 mg. a day, 16 patients developed toxic signs such as slurred speech, unsteady gaits, tremors, and "wooden" expressions. Improvement of these symptoms in seven patients became evident when the dosages were lowered to a maintenance level.

#### *G. Visual Disturbances.*

Four patients complained of blurred vision. They had difficulty in reading newspapers, books, and magazines. This did not appear to be related to difficulty in concentrating; all were carefully examined, and no demonstrable pathology was noted.

#### *H. Seizures.*

Six patients on daily dosages from 2,400 to 3,000 mg. had a total of 12 seizures among them. The occurrence of seizures seemed to be distinctly related to the level of dosage, as it was observed that the seizures no longer occurred when the dosages were lowered by 200 mg. each. This was found to hold true in all six of the cases. None of the patients had histories of seizures, although three of them had had lobotomies. No anticonvulsant medications were given.

#### *I. Cardiovascular Reactions.*

During the second week, three patients had vascular collapses, with fall in blood pressure, fainting and rapid pulse. A week later, however, three patients in the placebo group had similar reactions.

An attempt was made to determine if any error in dosage had occurred, but apparently none had; and physical and laboratory examinations revealed nothing. During the fourth week, one of the patients in the placebo group received a dose of 800 mg. of chlorpromazine through an error. Fifteen minutes later he collapsed, and his blood pressure registered 40/0. Although he received only this one dose of chlorpromazine, he improved remarkably during the rest of the study, and his ward adjustments, participation in activities, and ability to communicate increased. He became friendly, pleasant and spontaneous. His data were eliminated from consideration when statistical comparisons were made.

*J. Urobilinogen.*

Seventeen patients developed bile in the urine, as measured by the "ictotest," while on 2,200 to 3,000 mg. a day. This disappeared entirely when the dosage was decreased to 1,400 mg. or below. There were seven placebo patients who also had positive tests on one occasion, and three who had positive tests on two occasions. There was no clinical jaundice.

#### DISCUSSION

It is interesting to note that on both the Wittenborn Rating Scales and the MMPI, the placebo group was significantly higher on retest on some of the scales (thus showing increased psychopathology). In evaluating these findings, it should be kept in mind that these scales are differentiated, in the sense that the Wittenborn Rating Scale records behavioral observations of the "he is" variety, whereas the MMPI represents self-attitudes of the "I am" type. The apparent increase in pathology of the placebo group as measured by these two devices was supported clinically, since it was observed that the patients were considerably more hostile toward the writers, exhibited more bizarre behavior, and certainly showed more anxiety and disturbance than they had evidenced during the pre-experimental phase. A possible explanation of the increased disturbance in this group is general resistance of the patients to changes in their somewhat stable levels of adjustment. As part of this study, these patients were introduced to a more intensified form of activity therapy, as well as to increased social contacts, and one might expect an increase in anxiety, as well as increased hostility toward the personnel, because of being "pushed" along in this program.

The improvement of the drug group, as noted by the ward psychiatrists on the Wittenborn Rating Scale, was confirmed by all personnel working with these two groups. The lack of change in these drug patients on the MMPI is in accord with the psychiatric evaluation and suggests that, while the drug does result in improvement in overt behavior, it does not affect mentation to a significant degree.

It is important to note that there was a discrepancy between what was recorded on the rating scales and what the clinicians talked about in discussing the patients with each other. The clinicians observed that there were one or two patients who did request ward work. The others were much more co-operative before and seemed willing to enter into activities that have been mentioned. Enthusiasm and suggestion blinded the clinicians to some extent to the marked lack of spontaneity which was still present in most of the patients. When this was recognized, the staff was able to keep demands on the patients within their capabilities.

These findings strongly suggest that chlorpromazine alone is insufficient in the treatment of chronic schizophrenics. Rather, it opens the door to other approaches in treatment. The still-existent lack of spontaneity suggests that these patients would likely relapse to their former level of behavior if the drug was considered the final phase of treatment. On the other hand, without chlorpromazine, or some similar agent, these patients would not have responded so favorably to the treatment program.

#### SUMMARY AND CONCLUSIONS

Thirty-eight chronic schizophrenic patients, whose illnesses had a mean duration of eight years and who had failed to respond to other forms of therapy, were divided into two matched groups. Chlorpromazine was administered to one group according to an arbitrary high-dosage pattern, with a maximum dosage of 3,000 mg. per day. The dosage was prescribed for each individual, according to his physiological tolerance and psychological needs. The other group received placebos, and each control patient had the same number of tablets daily as his matched "partner" in the drug group. Milieu therapy was also prescribed individually as far as possible. The two groups were matched with respect to: age, length of hospitalization, duration of illness, Minnesota Multi-

phasic Personality Inventory profiles and scores on the Manifest Behavior Scales.

During a standardization period of four weeks, the patients were given the MMPI, were rated on a Manifest Behavior Scale by psychiatric aides, and on the Wittenborn Rating Scale by the ward psychiatrist. Both groups were then placed on placebos for two weeks before the intensive treatment period of three months was begun. In the middle of the three-month medication period, the patients were again rated on the Manifest Behavior Scale. At the end of the medication period, all the tests and measurements given during the standardization period were repeated. All of the drug patients are still on maintenance doses, and data for a six-month follow-up period are reported. Clinical evaluation, structured observations and physiological measurements were carried out at regular intervals throughout the study. Following the evaluations and retesting at the end of the experimental period, the placebo group was started on a "low dose" chlorpromazine regimen, and the results will be reported in a later paper.

1. The placebo group in this project showed very little change. Only two of this group showed clinical improvement, and one of them improved immediately when he received 800 mg. of chlorpromazine through error. Four in this group became worse, and 13 showed no change whatever. Possible reasons for adverse reactions are discussed.

2. Of the 19 chlorpromazine patients, 15 showed improvement, two showed very little change, and treatment of one was discontinued. Improvement varied from three patients who were able to adjust well at home to two who remained in a locked ward but were able to participate meaningfully in social activities.

3. The drug group showed significant improvement, as measured by the Wittenborn Rating Scale and the Manifest Behavior Scale. These patients improved significantly on 25 of the possible 90 items of the Manifest Behavior Scale; and the meaning of these changes was discussed.

4. A significant negative relationship was found between the degree of improvement and chronicity.

5. No changes were found in the drug group on the MMPI. MMPI results, as well as the findings of the Manifest Behavior Scale and clinical evaluations, suggest that while overt behavior

was improved with the use of the drug—in the areas of communication, destructiveness, disturbed behavior, co-operativeness and anxiety—mentation and self-attitudes were not affected to a significant degree during the four months reported.

6. Usual side reactions were encountered, with one patient dropped from the drug group because of a fulminating skin reaction of unusual severity. Six patients had a total of 12 convulsions among them while on dosages of over 2,400 mg. per day. These convulsions were controlled by decreasing each dosage 200 mg. below the dose at which the seizure occurred. There were no other serious complications.

7. In some cases, toxic signs masked the improvement which did not become apparent until the dosage had been lowered by several hundred milligrams.

8. Long-term results appear even better, as the patients continued to hold their improvement for an additional 12 months, at which time this report was prepared. A longer term follow-up report will be made.

9. It was a clinical impression, supported by objective data, that chlorpromazine resulted in a marked reduction of the patients' emotional turmoil. This reduction in emotional turmoil fostered clinical improvement which then allowed the patient to utilize environmental and interpersonal therapies more effectively. Active milieu therapy is considered to be an essential part of the therapeutic program, without which the benefit gained through the use of chlorpromazine would have been less satisfactory, less profitable and less sustained.

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## THE CLASSIFICATION OF "MENTAL ILLNESS"\*

### *A Situational Analysis of Psychiatric Operations*

BY THOMAS S. SZASZ, M.D.

All history teaches us that these questions that we think the pressing ones will be transmuted before they are answered, that they will be replaced by others, and that the very process of discovery will shatter the concepts that we today use to describe our puzzlement.<sup>1</sup>, p. 124

J. ROBERT OPPENHEIMER

The problem of psychiatric nosology has posed a persistent difficulty during the past half-century because, it seems to the writer, it is one of those problems that is insoluble in the form in which it is usually tackled. Certain fundamental concepts and technical aims must be clarified first. Only after this has been accomplished will we be in a position to return to the problem of psychiatric nosology and re-examine it in new light.

#### WHAT DOES PSYCHIATRIC NOSOLOGY CLASSIFY?

The need to scrutinize the very notion of "psychiatric nosology" and to divide it into workable fragments should be stated emphatically. The reason is that this problem encompasses, as far as one can see, the following, often mutually exclusive, methods and tasks. First, in relation to the word "psychiatric," there is ambiguity about the domain of this field. Is psychiatry a branch of medicine? And if so, do we mean by this that it is a therapeutic discipline based (as far as possible) on the methods of physics and chemistry? Or do we mean that it is the study of human behavior and human relationships? And if so, do we conceive of it as a branch of, or allied to, psychology and sociology? If this is what we mean, then we are committed to the psychological method and frame of reference. We cannot have both, or a combination of the two, either by simply wishing or by coining a word like "psychosomatic."<sup>2</sup> To illustrate this, consider the diagnosis of general paresis. Does this diagnosis refer to a physicochemical or a psychologi-

\*This paper is from the department of psychiatry, State University of New York, Upstate Medical Center, Syracuse, N. Y. It was presented in part in the theoretical symposium on "Psychiatric Nosology," at the 113th annual meeting of The American Psychiatric Association, Chicago, May 11-17, 1957; an abbreviated version of it was published in *The American Journal of Psychiatry*, 114:405, 1957.

cal phenomenon? Clearly it refers to the former. It is not characteristic, or even descriptive, of any particular behavioral event. How then can one hope to bring it into a meaningful relationship with other "psychiatric diagnoses" such as hysteria, reactive depression or situational maladjustment? These, and many others, refer to behavioral events and are meaningless in a physicochemical frame of reference. (They are, however, modeled after, and are not meaningless in, a medical framework of concepts.) Yet, such dissimilar concepts are now all subsumed under the heading of "psychiatric diagnosis." This is as though, in the periodic table of elements, we would find coal, steel, and petroleum, interspersed among items such as helium, sulfur and carbon. In the writer's opinion, this is one of the reasons why the taxonomic system known as "psychiatric nosology" does not work and why attempts to improve it—which have not taken this factor into account—have failed to satisfy anyone but their authors.

A second source of difficulties arises as a result of the several implications of the word "nosology." Nosology means the classification of "diseases." This immediately casts psychiatry into the medical (and physicochemical) mold into which it fits only according to the first definition of this discipline.<sup>3</sup> In this view, psychiatry is the study of diseases of the brain, and psychiatric nosology is the classification of these diseases. Others, however, regard psychiatry as the study of diseases of the "mind"; "psychopathology" is the nosology based on this scheme.<sup>4</sup> The trouble here stems from the concept "mind." Still others have attempted to overcome this difficulty by recourse to a system of "disorders of behavior."<sup>5</sup> Thus far, three categories of concepts (brain, mind and behavior) have been enumerated. To the taxonomy of each of these, the expression "psychiatric nosology" is applied. Not only do psychiatrists use different categories, usually without specifying their schemes, but concepts from two or all three of these categories are often combined within a single taxonomic scheme (for instance, general paresis, latent schizophrenia, and homosexuality).

Although the phrase "psychiatric nosology" means principally the classification of psychiatric disorders (whatever these may be), modern developments in psychiatry have led to further taxo-

nostic possibilities. This state of affairs has resulted from the fact that psychiatry consists of *both* a basic science and of a clinical technique (or several such techniques). It is only the latter that is oriented toward "diseases," "diagnosis" and "treatment." The former is oriented, like all sciences, toward an essentially non-judgmental (nonevaluative) understanding of the phenomena which it studies. "Nosology" in this context becomes akin to the taxonomic system of the physical sciences, in that it aims at a system of *ordering* phenomena that is useful not for "treatment" but for "scientific mastery" (whatever that may mean, depending upon the developmental stage in which the science finds itself and upon social factors). Some of the classificatory concepts of psychoanalysis (for example, repression as a characteristic feature of "hysteria") resemble most closely such nonevaluative concepts of classification. Unfortunately, however, most of these concepts have been re-introduced into a medically-minded system of psychopathology.<sup>6</sup> The foregoing categories to which the words "psychiatric nosology" may be, and often are, applied are summarized in Table 1.

Table 1. Four Basic Categories of Psychiatric Nosology

Concept of Psychiatry	Nosology
Its subject matter, method and social aim	
I	I
Diseases of the brain; the physicochemical method; therapy.	A system identical with, and fitted into, the diagnostic categories of medicine (e.g., general paresis).
II	II
Diseases of the "mind"; the methods of either physics or of psychology; therapy.	A system similar to the diagnostic categories of medicine (e.g., toxic psychosis, schizophrenia).
III	III
Human behavior and human relationships; the psychological method; therapy.	A system based on the medical model, with assumed or explicit norms for human behavior (e.g., homosexuality).
IV	IV
Human behavior and human relationships; the psychological method; increased scientific mastery.	A nondiagnostic system of classification, based on significant recurrent patterns (e.g., the concept of transference). This is a hypothetical taxonomic system that would have to be worked out. Even if workable, it would be without value for psychiatric therapy.

## AN OPERATIONAL APPROACH TO PSYCHIATRIC NOSOLOGY

Classification is but a special case of the more general psychological phenomenon of category-formation. This process depends, as is known, upon the psychological characteristics of the person engaged in forming categories and upon the social situation in which he participates. The dependence of the psychological variable upon brain function, for example, has been studied and demonstrated in an impressive fashion by Kurt Goldstein.<sup>7-9</sup> The effect of the social situation on category-formation, is a matter of common knowledge and may escape attention precisely because it is so obvious. In other words, it would be banal to stress that from the point of view of the economist or of the jeweler there are no "similarities" between coal and diamond. In an economic situation, one may distinguish diamond, gold, platinum and money as members of the same category, one that pertains to *economic value*. The chemist, on the other hand, may classify diamond and coal as "chemically similar" members of the category called *carbon*. Surely, there is no need to belabor this point. The example cited illustrates what is meant here by an operational approach to nosology; the word "operational" is used in this context to denote not only the characteristic methods of observation but also the social situation in which the observation is made and its purposes. This extension is inherent in the philosophy of operationalism.<sup>10</sup> Let us look at psychiatric nosology in this light.

It is apparent at once that the social situations in which so-called psychiatric observations are made are diverse, and yet it is generally assumed that one and the same system of classification should be useful for all of them. One may name but a few of the major "psychiatric situations," without implying that the list is exhaustive: The mental hospital, private psychiatric practice (including the psychoanalytic situation), the child guidance clinic, the psychoanalytic training system, the military service, the court of law, and the prison. Psychiatric diagnoses are made and used in each of these settings.<sup>11-14</sup> Yet the methods employed and the purposes for which diagnoses are made differ. The writer submits, therefore, that one cannot expect to be able to take a system of psychiatric nosology developed in one situation and expect it to be meaningful and serviceable in another.

This may seem like a simple problem for which the writer has proposed a self-evident solution. Yet, it is equally obvious that

items taken from various systems of psychiatric classification are shuffled about on the current (American) social scene with great abandon. Thus, some concepts taken from the context of mental hospitals are applied to politics and law, while other concepts are transferred from psychoanalysis to general psychiatry. This practice is so widespread that it does not require illustration. Nor is it limited to certain social situations in which scientific considerations are not primary issues (such as situations in the courts), for this practice has fully penetrated into psychoanalysis itself. The Central Fact-Gathering Committee of the American Psychoanalytic Association was organized in 1953 to collect and evaluate data on the "diagnosis" and "treatment" of patients seen in psychoanalytic practice. The diagnostic categories used in this survey are those listed (in part) in the American Psychiatric Association's *Standard Nomenclature of Mental Disorders*. In a recent mimeographed report of the fact-gathering committee, the following statement<sup>15</sup> appeared:

We ourselves find that sometimes the difficulty in using the nomenclature arises from our own inability to diagnose certain cases. We may well have to set up a group of "diagnosis undetermined, or undeterminable cases" with notes of the problem. Recall that some medical cases cannot be diagnosed even after post-mortem microscopic examination! As an example, I note this recent case at a clinical pathological conference: Was it a case of tuberculosis with leukemoid reaction (q.v.) or a case of leukemia with a terminal tuberculosis!

This example illustrates several of the epistemologically untenable practices mentioned in this essay. In the methods of this survey, not only is there a transposition of diagnostic terms and concepts from "general psychiatry" (whatever that may be) to the psychoanalytic situation, but there is a further assumption (never fully explicit) that there is a high degree of similarity between traditional medical models of "disease," on the one hand, and the sort of problems dealt with by psychoanalysts on the other. It seems to the author that this position is untenable.<sup>3, 16, 17</sup> The psychoanalyst's cases cannot be fitted into the diagnostic categories of the "standard nomenclature," and the concept of "treatment" applies poorly to the psychoanalytic situation.

It is interesting to note, further, that Diethelm, without consideration of situational relevance such as has been discussed,

came to a conclusion about the concept "psychosis" that is very much in harmony with the thesis of this paper. He stated:

"The purpose of this presentation has been to bring out the fallacy of the concept 'psychosis' which has dominated psychiatric thinking and facilitated loose and unscientific thinking, especially in the realm of psychotherapy. It must be the task of psychopathologists to bring the issue to an open and critical review, so that the term psychosis will disappear from psychiatric usage and literature, with the possible exception of a legal application."<sup>18</sup>, p. 31

It is impossible to undertake a detailed consideration of the characteristics of the various psychiatric situations that have been listed. To do so would require, at the very least, a separate treatise for each. The writer has offered fragments of such operational descriptions of specific psychiatric situations elsewhere for example, for the psychoanalytic situation,<sup>17</sup> for the psychotherapeutic situation with the schizophrenic,<sup>19</sup> and for the legal situation.<sup>20</sup> A condensed tabulation of the salient features of these situations is listed in Table 2. (See also the explanatory notes for this table.)

Someone might ask, what is it that corresponds in these situations to the differences in the classificatory schemes of the jeweler and the chemist, in the example cited. The present comments on Table 2 will be restricted to answering this question, with the hope that this will illustrate and clarify the general problem under discussion. For this purpose, one may consider three situations: The situation of the psychiatrist in a state mental hospital, the psychoanalytic situation and the situation in the court of law (psychiatric expert testimony). In the first of these, the relevant category into which the patient must be fitted is principally that of psychosis versus nonpsychosis.<sup>18, 23</sup> The former tends to justify forcible retention in the hospital, the latter does not. Also, the diagnosis of psychosis, in this context, legitimizes the use of various, sometimes drastic, therapies. In the psychoanalytic situation, the same term, that is "psychosis" (or "psychotic") refers *only* to certain mental mechanisms or patterns of human relationships; it does not refer to overt behavior or social judgment. This method of classification is somewhat analogous to that of the chemist, and consequently the concept "psychosis," as used here, will *not* point to any significant phenomenological similarities between the patient under study and others who may be either inside or outside

of mental hospitals.<sup>19</sup> Finally, in the legal situation, psychiatric diagnostic terms must be categorized in terms of two mutually exclusive classes, those who are punishable and those who are not.<sup>21</sup> This is inherent in the legal situation just as it is inherent in our present economic situation that diamond is more valuable than coal. A nonjudgmental, purely descriptive, system of classification—while it may be as accurate as it would be to state that both diamond and coal are forms of carbon—is no more appropriate to the legal situation, than would be its analogue for purposes of banking. If this reasoning is correct, the writer believes that a more general appreciation of these considerations would clear the way for further scientific advances in the psychiatric field.

Before turning away from this discussion of the operational aspects of psychiatric nosology, the writer wants to comment briefly on the recent history of psychiatry, viewed in this light. To briefly restate the problem, the questions asked were: *Whom do we study, where and with what methods?* Table 2 was offered as a partial answer to this question (omitting, by and large, detailed considerations of method). Let us ask the same questions about the principal psychiatric figures since Kraepelin.

Kraepelin's chief objects of observation were inmates of mental hospitals.<sup>24</sup> He studied them simply by direct, common-sense observation. The underlying assumption was, first, that they suffered from diseases much the same as other diseases with which physicians were familiar; and, second, that society and the physicians who studied them were "normal" and constituted the standards with which their behavior was compared. Accordingly, patients were subsumed under categories ("diagnoses") based on the behavioral phenomena ("symptoms") that were judged to be dominant. The spirit of the inquiry precluded emphasis on specifically individualistic features and determinants. Kraepelin's approach, as Zilboorg<sup>25</sup> noted, was, therefore, at once humane and inhuman. He was interested in man, but was not interested in the patient as an individual.

The psychiatric situation that characterized Bleuler's work<sup>26</sup> was essentially similar to Kraepelin's. The main difference lay, the writer thinks, in the fact that Bleuler had a much greater interest in the patient as a person. He, therefore, noted more personally characteristic phenomena and saw, for example, that patients with dementia praecox were not really "demented."

Table 2. Characteristic Features of the Principal Psychiatric Situations on the Current American Scene

Social Setting	Object of Observation	Observer	Principal Aims of Classification (Diagnosis)	Principal Action Patterns
<i>Mental hospital.</i> a. State Hospital.	<i>Hospitalized mental patient, who has been admitted "voluntarily," or against his will ("certified"). Patient is disordered in such a way that he is in overt conflict with social norms.</i>	<i>Hospital psychiatrist.</i> a. <i>An employee of the state and dependent upon it for his personal gratification and advancement; in many ways, principally an agent of society.</i>	a. To justify retention of patient in hospital, or his discharge from it; to "explain" by giving disorder a name.	a. Segregation and forcible restraint versus release and noninterference.
			b. To explain patient's psychological disorder and to indicate the nature of the treatment required; to communicate with others.	b. Treatment versus refusal of treatment on grounds of unsuitability.
<i>Private practice.</i> a. General psychiatric practice.	<i>Private patient.</i> a. Patient and members of his family; records; information from other sources, such as medical colleagues, etc.	b. <i>An employee of a private hospital.</i> His allegiance is divided between the needs of hospital and the needs of the patient.*	a. To facilitate the psychiatrist's thinking and management of the case; to communicate with others.	a. Various patterns of "treatment."
		a. <i>Psychiatrist</i> — principally an agent of the patient, and paid by him. Besides the patient, however, he is also oriented to, and may communicate with, the patient's family and his own professional colleagues.		

Table 2. Characteristic Features of the Principal Psychiatric Situations on the Current American Scene (Continued)

Social Setting	Object of Observation	Observer	Principal Aims of Classification (Diagnosis)	Principal Action Patterns
b. The psychoanalytic situation.	b. The patient only.	b. <i>Psychiatrist</i> —an agent solely of the patient.	b. To facilitate the psychiatrist's thinking and management of the case; to organize and present observational data for scientific purposes.	b. The psychoanalytic method of treatment. "Interpretation," continuance and stopping of treatment.
<i>Child guidance clinic.</i>	<i>Child-patient, and his parents</i> who are potential patients.	<i>Child psychiatrist.</i> An agent of the parents. The assumption that his work on behalf of the child-patient will also benefit the parents is implicit in his role.**	To organize for scientific understanding the characteristic features of the child-parent interaction; to serve as a guide for treatment; to communicate with others.	Decision-making about principal loci of "disorder" (the "pathogens"); treatment of one or several members of the family.
<i>The psychoanalytic training system.</i>	<i>The "psychiatrist-patient"</i> (and sometimes his psychoanalytic training activities).	<i>Training analyst.</i> An agent both of the patient and of the analytic training system. The assumption that his work on behalf of the "candidate-patient" will also benefit (or will not be harmful to) the professional organization whose representative he is, is implicit in his role.†	To evaluate and judge the personality of the candidate as a guide to whether, or at what rate of speed, he is to be allowed to progress in his training schedule.	Decision-making about problems of psychoanalytic treatment, coupled with decision-making about qualifications for occupational role and social status.

Table 2. Characteristic Features of the Principal Psychiatric Situations on the Current American Scene (Concluded)

Social Setting	Object of Observation	Observer	Principal Aims of Classification (Diagnosis)	Principal Action Patterns
<i>Military service.</i> Military hospital, clinic, or court.	<i>Military personnel.</i> The patient and all those with whom he interacts.	<i>Military psychiatrist.</i> An agent of the military service. He can function as an agent of the patient only insofar as this creates no conflict with his principal role.**	To justify action pattern accorded to patient; to establish communication between psychiatrist and other agents of the service who have jurisdiction over the patient (e.g., compensation boards).	Return to duty, "treatment," or discharge from the service.
<i>Court of law.</i> The "legal situation." Psychiatric expert testimony.	<i>Object of observation poorly defined or sometimes undefined.</i> It is assumed to be the defendant, but it may be a witness or even society itself.†	<i>The psychiatrist as a legally recognized "expert."</i> He may be an agent of (a) the defense, (b) the prosecution, or (c) the court. In each case, he is committed to obey the rules that govern this particular social situation.	To establish and convince others that the defendant (or others) is morally wrong or not, guilty or not, and so forth; i.e., classification serves to justify a specific action that is being advocated.	Decision-making about guilt or innocence; punishment or acquittal.
<i>Prison.</i>	<i>Prisoner.</i> A person who has violated the law and is punished for it by confinement.	<i>Prison psychiatrist.</i> An agent of society. The assumption that his work on behalf of the prisoner-patient will also benefit society is implicit in his role.**	To classify antisocial behavior along the model of disease so as to permit an allegedly nonethical mode of influence to be introduced into the action-pattern designed to alter the patient.	Efforts toward rehabilitation or prolonged segregation from society, for the latter's protection.

Now we come to Freud, who, most will agree, saw much more than his predecessors. One may attribute this to his "genius," as if this word would explain anything. The writer would like to suggest, rather, that he saw more, partly because he was not fettered in making his observations by confinement to a single situation with limited techniques. Indeed, he enlarged the psychiatric situation to include almost anything that came across his horizon. Thus, he rapidly shifted from pure clinical observation, with or without hypnosis, to observations of himself, of other socially normal individuals, and of so-called neurotics, as well as to observations on the biographies and autobiographies of artists, "psychotics" and others. On the whole, he, too, tended to use society and the observer as norms against which the patient and his conduct were measured. In contrast to his predecessors, however, he made this standard explicit. Before his time, it was not fully realized that such a standard was implicit in the then current schemes of psychiatric nosology. The nosological scheme that Freud used, as might be expected from what has just been said, was chaotic. He retained the Kraepelinian scheme as far as the diagnostic words were concerned but used them as he pleased. This has resulted, among other things, in repeated attempts to re-label his cases by later authors.<sup>27</sup> Once again, Zilboorg<sup>28</sup> clarified

\*See, in this connection, Stanton and Schwartz, *The Mental Hospital* (Ref. 13). This work represents the most detailed and accurate exposition that has been presented so far of the characteristic features of the psychiatric situation in the private mental hospital.

\*\*In every situation one may ask, "Whose agent is the psychiatrist?" The writer has discussed this problem both in general terms and in relation to some specific situations in several recent publications. (Refs. 3, 14, 20-22.)

†See, in this connection, the writer's paper "Psychoanalytic Training: A Socio-Psychological Analysis of Its History and Present Status," published in the *International Journal of Psychoanalysis*. (Ref. 22.)

‡In what may be considered the average criminal trial, the psychiatrist's object of observation is the defendant, and the latter's sanity or lack of it is the issue to be determined. In other cases, however, for example when the psychiatrist functions as adviser to the court, one gets the impression that his object of observation may be the defendant *plus* the society in which he lives; this approach often leads to the incrimination of "society" itself in the criminal act. In still other cases, of which the Hiss trial is an outstanding recent example, psychiatric testimony may be introduced to incriminate and to discredit a witness; here, one would have to conclude that the psychiatrist's object of study is a particular witness, or perhaps the trial itself. The subject clearly requires much further study.

the matter by emphasizing that Freud cared little about the diagnostic labels he used. He concentrated, as one knows, on accurate description, on reconstruction, and on the formulation of new abstractions to account for what he observed (transference, repression, reaction-formation, and so on).

There have been attempts to use psychoanalytic abstractions in the formation of new psychiatric nosologies. These have failed because they have mimicked the Kraepelinian and Bleulerian systems (for instance, by suggesting that hysteria be diagnosed by the presence of repression as the chief mechanism of defense). Such attempts could succeed, if at all, only by limiting their range of applicability, and by adhering to operational criteria (e.g., the patient's reaction to the analytic situation<sup>29</sup>).

Adolf Meyer's approach was a great departure from the basic concepts of Kraepelin and Bleuler in that he did not subscribe to the notion that mental disorder is a phenomenon akin to physical disease.<sup>30, 31</sup> Yet he remained more closely allied in his work to these men than to psychoanalysis, probably chiefly because he continued to focus attention principally on so-called "clinical material," that is, on those who are mentally ill by social criteria. His method was, by his own statement, that of "common sense,"<sup>32</sup> but in his thinking he combined biological, historical, psychological and social considerations. He developed a system of classification, not of "disease" but of "reaction types," meaning thereby that disorders of behavior may be classified according to their predominant symptoms. It is important to note that the technical terms—the "ergasias"—which Meyer suggested for these categories were never widely accepted in spite of his great influence on American psychiatry. Within a few decades his system of nosology became a historical relic.

Kurt Goldstein has become well-known for his observations in still another psychiatric situation: He studied the brain-injured, combining in his approach the methods of neurology, clinical psychiatry and psychological testing.<sup>7</sup> In addition, he introduced in his studies certain philosophical and linguistic considerations<sup>8</sup> which have also proved significant. While his name is not customarily associated with any nosological innovations, it should be noted that he did create two new categories—the concrete and the abstract attitudes<sup>9</sup>—and that these grew out of the particular situation in which his observations were made.

One may also note, at this point, that Bleuler's, Freud's and Goldstein's nosological categories continue to be used. All make good sense in the situations in which they originated. They have, however, since been removed, transplanted and combined with one another and have then been used in all manner of situations. Is it then surprising that our current psychiatric nosology is a modern tower of Babel? Eclecticism is no doubt a healthy antidote to factional fanaticism. But in modern psychiatry, particularly in this country, it may have been carried too far, implicitly assuming that this tendency is without dangers of its own. Yet, our chaotic nosology may well be a part of the price that we have unwittingly paid for excessive eclecticism.\*

Considerations of some recent work in psychoanalysis<sup>17, 20, 24, 25</sup> would throw further light on the interrelations of the social structure, the methods of, and the classificatory schemes appropriate to, various psychiatric situations. (See Table 3.) Suffice it to note that most of these developments have increasingly abandoned the traditional nosological concepts and have developed new concepts and terms of their own. Harry Stack Sullivan's contributions,<sup>26, 27</sup>

\*This criticism of eclecticism applies less to therapy than to psychiatry as a branch of science. The uselessness of stubbornly applying particular methods of therapy to all sorts of patients and in all manner of situations justifies, it seems to the writer, a certain measure of eclecticism in therapy. This is much like the improvisations necessary to meet the exigencies of everyday life, from which, however, no inferences can be drawn concerning the methods of science. The drawing of inferences from the area of therapeutic necessity to that of scientific method and theory has probably been the greatest stumbling block to progress in recent decades both in psychoanalysis and in so-called dynamic psychiatry.

For a comprehensive discussion of the shortcomings inherent in un-self-critical eclecticism, the reader's attention is called to Glover's *Freud or Jung?* (Ref. 33.) The following passages from this work illustrate Glover's position and are pertinent in connection with the present concern with nosology:

"Preening himself on his scientific detachment and his capacity to take only the 'best' from each school, the eclectic is not very much concerned whether a little bit of Freud and a little bit of Jung when dovetailed with little bits of Adler or Stekel form a crazy pavement so long as the pavement offers a short cut to therapeutic success, a criterion which, as we shall see, does not establish the validity of any theory. The eclectic in fact does more than any other practitioner to obstruct the progress of clinical psychology. It is no service to psychology to gloss over fundamental differences [p. 16].

"A plethora of expository surveys of 'modern' psychology bears witness to the fact that eclecticism is generally regarded as a form of objectivity, reflecting credit on those who cultivate it. This is a view which the casual reader, always inclined to see fair play and confusing eclecticism with impartiality, feels strongly disposed to support. Believing that there must be at least two sides to any question, he finds it hard to conceive that one side may rest on total error [p. 187]."

Table 3. Psychiatric Situations Characteristic of the Work of Outstanding Psychiatrists Since Kraepelin

Name of Observer	Observed	Location and Social Position of Observed	Method of Observation	Purpose of Classification Proposed
Kraepelin	Inmates of mental hospitals.	Hospitals (both mental and general); patients from all social classes, but predominantly the poor and uneducated.	Clinical observation of overt behavior.	To create a nosological system in psychiatry similar to that of medicine; to be able to prognosticate.
Bleuler	Inmates of mental hospitals and, to a lesser extent, out-patients.	Mental hospital and clinic; patients from all walks of life.	Clinical observation, influenced by early theories of psychoanalysis.	Same as above; also, to arrive at a diagnostic schema that would be useful for psychiatric treatment.
Freud	"Neurotics," the observer himself, writings of artists, "psychotics," and others.	Private office; most patients well-to-do, well educated, and generally well-attuned to verbal communication with others.	Clinical observation, hypnosis, free-association, and the gradual development of the psychoanalytic method proper.	A chaotic mixture of purposes includes those above, plus the wish to order "psychopathology" according to: (1) characteristic defenses against conflict, and (2) criteria that should help the analyst to decide whether the patient is amenable to treatment by analysis or not.

Table 3. Psychiatric Situations Characteristic of the Work of Outstanding Psychiatrists Since Kraepelin (Concluded)

Name of Observer	Observed	Location and Social Position of Observed	Method of Observation	Purposes of Classification Proposed
Meyer	"Mental patients."	Hospitals and clinics; patients from all walks of life, with a probable preponderance of the poor and uneducated.	"Common sense."	To create a taxonomic system of "reaction types" the specific purpose of which was never defined; it was presumably to be equally useful for scientific clarification and therapeutic work.
Goldstein	Brain-injured patients.	Hospitals specially set up for the study and treatment of brain-injured soldiers; men from all walks of life who suffered brain injuries, mostly in war.	Neurology, clinical psychiatry, and psychological testing, used in a novel philosophic and linguistic framework.	To describe, for purposes of scientific ordering, characteristic features of the phenomena observed.
Sullivan	Predominantly "schizophrenic" patients.	Mental hospitals and private office.	Clinical psychiatry, psychoanalysis, and modifications of the latter with emphasis on face-to-face interview and stress on the mutual influences that patient and psychiatrist exert on each other.	To describe "mental mechanisms," mostly for purposes of communicating with other psychiatrists.
Current work on psychoanalytic technique (e.g., K. B. Eisler, W. R. D. Fairbairn, and others).	The patient in analysis.	Private office; the analytic situation.	The psychoanalytic method (e.g., the primary model technique), sometimes viewed in terms of object relations.	To describe, and possibly systematize, various reactions on the part of patients to the analytic situation.

for example, cannot be fitted into our current official nosology without doing the utmost violence both to him and to our nosology. The same is true of other current contributions to the psychology of "schizophrenia" and of the entire trend toward an object-relationship type of approach.<sup>34</sup> These considerations underscore the need to develop adequate systems of classification, rather than to continue paying lip-service to an outmoded nosology, as we progress in our psychiatric knowledge.

#### PANCHRESTONS IN PSYCHIATRY

Although the main objective in this essay is to consider the psychiatric and sociological aspects of the problem of psychiatric nosology, it is impossible to avoid touching at least briefly on a related consideration that is most pertinent to this subject. In connection with the word "protoplasm," Hardin has called attention to the danger of words that "explain everything." He writes:

Such enemies of thought, like all enemies, may be easier to spot if we label them. Such "explain-alls" need a name. As we borrow from the Greek to call a "cure-all" a *panacea*, so let us christen an "explain-all" a *panchreston*. The history of science is littered with the carcasses of discarded panchrestons: the Galenic *humours*, the Bergsonian *elan vital*, and the Drieschian *entelechy* are a few biological cases in point. A panchreston, which "explains-all", *explains nothing*.<sup>35</sup> p. 113

It is interesting to note, further, that the word "panchrestus" (an adjective) was used by Galen. In W. Turton's *A Medical Glossary* (1802), "panchrestus" is defined as "An epithet of a collyrium described by Galen, and so named for its general usefulness."<sup>36</sup> One is led to surmise, moreover, that Galen's personality may be related to the origin and use of this word, and beyond it to the general problem of what the writer has termed "global explanations." In this phenomenon, one simply encounters a special case of the common human tendency toward megalomania,<sup>40</sup> a disease to which no group of people, scientists included, have as yet developed lasting immunity. Castiglioni's following characterization of Galen rounds out the historical background pertinent to the term "panchreston":

Galen knows everything, has an answer for everything; he confidently pictures the origin of all diseases and outlines their cure. He is the incarnation, perhaps for the first time in history, of the physician who

regards himself as omniscient and whose attitude of authority emanates from every act and every word.<sup>41</sup> pp. 220-221\*

Clearly panchrestons have played, and continue to play, an enormous role in psychiatry and psychoanalysis. Percival Bailey's address<sup>42</sup> in 1956 to the American Psychiatric Association may indeed be regarded as a discourse on the existence of panchrestons in psychiatry and on the uses to which they are put. He overlooked, however, all that we do know, and all that has been discovered during the past half-century. By concentrating attention on panchrestons, one naturally limits himself to that which remains to be elucidated. The writer would like to emphasize this point, in order to make it clear that his subsequent comments are not intended as a wholesale criticism of psychiatry, or any of its branches, but are offered simply as additional considerations to be taken into account in connection with the problem of how to improve psychiatric nosology.

It is clear that many terms—some diagnostic, like schizophrenia, others nondiagnostic, like libido—function as panchrestons. In other words, "schizophrenia" is supposed to "explain" so-called insane behavior in much the same way as "protoplasm" explained the nature of life, and "ether" the manner in which energy travels through space. Not only do these words *not* explain the phenomena in question, but, as Hardin<sup>43</sup> rightly emphasized, they hinder understanding and explanation. If this is so, it means that just as "ether" and "protoplasm" obscured important problems in physics and biology, so "schizophrenia" (and many other psychiatric words) may obscure fundamental problems in psychiatry.

This touches on an exceedingly important problem, but one that is in no way peculiar to psychiatry. Accordingly, one need not dwell on it, and it may be assumed that analogous developments in other sciences constitute a lesson that we must learn. From a point of view of psychiatric nosology, this means that categories such as "schizophrenia" may be doubly harmful: First, such categories are unsatisfactory as readily verifiable concepts for purposes of classification; and second, they give rise to the misleading impression that there "exists" a more-or-less homogeneous group of phenomena which are designated by the word in question (for example, "schizophrenia," "hysteria," "malingering"). If

\*The writer is indebted to Dr. Arthur Ecker for calling these references to his attention.

this line of thought is correct—as the writer believes it is—it leads to the realization that the “problem of schizophrenia” which many consider to be the core-problem of psychiatry *today*,\* may be truly akin to the “problem of the ether.” To put it simply: There is no such problem. The task is, rather, to re-define our questions so that they become manageable with the technical tools at our command. In the case of “schizophrenia,” this will mean, first a conceptual clarification of the manifold meanings of the word, and, then, the undertaking of work along clearly-defined methodological lines—whether biochemical or psychoanalytic—aimed at elucidating specific “facts,” rather than “explaining” global concepts. Thus, biochemical studies may throw light on disorders of brain function, much as the discovery of the histological lesions of general paresis threw light on the presence of physically damaged brains in parietic patients. There is no reason to believe that such a thing may not prove to be the case for *some* patients who by current criteria might be labeled “schizophrenic.” Similarly, studies along psychological and social lines should prove enlightening about processes of object relationships, the use of language and symbol-formation and other features characteristic of the behavior, in certain situations, of so-called schizophrenic patients. It would be a mistake to believe—or so it is submitted here—that such researches will “explain schizophrenia.”\*\* Instead

\*The judgment of what is, or is not, a panchreston in science cannot be evaluated properly, it seems to the writer, without paying due attention to the element of *time*. In other words, the question really is: At what time in the history of a given science does a word, or concept, *become* a panchreston? Thus, ether, for example, did not *function* as a panchreston in physics in the days of Newton; it became a panchreston, however, in the days of Becquerel, Curie, Michelson, Morley, and Einstein. Similarly, schizophrenia was a useful term and concept when it was first introduced by Bleuler, and remained so for some time afterward. The question is: Is it still useful or has it become, *today*, in the light of newer knowledge (particularly in psychoanalysis and sociology), a panchreston? Only the future historian of science will be able to answer this question with assurance. Yet no matter how uncertain we may be about how to best answer this question, our work and the course which it will take will depend heavily on the position we take (knowingly or otherwise) on it.

\*\*In the 1956 theoretical symposium Pauling stated: “I am sure that most mental disease is chemical in origin, and that the chemical abnormalities involved are usually the results of abnormalities in the genetic constitution of the individual” (Ref. 43, p. 492). This is a sweeping claim that is buttressed, at present, by little more than the scientific prestige (derived from another field) of its distinguished author. It seems, to the writer, to be entirely plausible that investigations into what Pauling calls “molecular diseases” may prove exceedingly fruitful for our understanding of the physical basis of some aspects of human behavior. It is not in keeping with the spirit

what may happen is that various behavioral processes will be better understood and the need for the word "schizophrenia" will disappear.

#### A RECAPITULATION AND SOME FURTHER CONCLUSIONS

In the preceding pages, psychiatric situations and nosologies (more-or-less) appropriate to each were discussed in the light of the philosophy of operationalism. This word is used to designate that principle of scientific philosophy which emphasizes the overriding importance of an explicit awareness of the particular methods of observation used in each study. The writer has extended its use, somewhat, to include in the concept of "method" the nature of the social setting in which the observation took place. This extension is implicit in the principles of operational philosophy, and it has been explicitly developed by students of what is often referred to as the "sociology of science." The relevance of this extension to the study of psychiatry need not be belabored, since we are fully aware today of the immense significance of the interpersonal and social matrix in this area of knowledge.

The brief sketches of the various psychiatric situations that have been presented were offered to identify these situations clearly and to show that they differ in one or several parameters. Thus, there may be differences in the person and position of the observer and the observed, and there may be variations in the aims for which the classification ("diagnosis") is made, or in the principal action-patterns inherent in the situation. It must be concluded that to hope that one and the same system of psychiatric nosology should be serviceable in all of these situations is to expect too much. Contrariwise, it is reasonable to assume that multiple nosological systems, each serviceable for one situation but not for others, may be developed without undue difficulties. Indeed, there are some in everyday use today, as for example, the categories of "sane-insane" as used in jurisprudence or "transference-reality" as used in the psychoanalytic situation. The notions of sane and insane pertain to the legal situation and can be correlated with

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of the "scientific attitude," however, to hold out this (or for that matter any other) specific investigative technique as one that promises wholesale solution of a problem as poorly defined as that of "mental disease" (an expression that no doubt will also soon qualify for the title of panchreston).

the action-patterns of punishment and acquittal.<sup>20</sup> The notion of transference pertains to the psychoanalytic situation and expresses the analyst's inference concerning some aspects of the patient's behavior: To the extent to which it is patterned upon past object relationships that are now re-experienced in relation to the analyst, it is "transference"; insofar as the behavior reflects the patient's current orientation to (external) objects, it is not "transference" but is considered to be "reality-oriented." None of these concepts can be readily applied in other situations, although our so-called "common sense," and the needs of society, often press us, as psychiatrists, to use all available psychiatric notions in every conceivable situation. This sort of tendency has led the psychiatrist to be viewed—both by himself and by others—as a "universal social expert" who can offer "scientific" advice on all manner of problems ranging from how to raise children to how to pick men who will be "safe" political leaders. This "global" (not to say "megalomaniac") view of psychiatry not only cannot lay claim to being "scientific"; but—and this may be even more damaging in the long run—it distracts attention from the truly worth-while advances that have been made, and that are being made, in the psychiatric field.

All of this, as the writer has said, runs counter to "common sense," and much of it runs counter to a currently prevalent tendency toward unbridled eclecticism (almost as if this were a "good" thing in itself) as well as to a widespread predilection for a "global" type of psychiatric research (such as attacks on the problem of "mental health" or "schizophrenia"). The need for science to deny (or more precisely, to transcend) "common sense" has been repeatedly emphasized, particularly by Bridgman.<sup>44</sup> It was cogently re-emphasized recently by Hardin, when he stated:

In the necessity of discarding "protoplasm", biology is now confronted with a painful decision of the sort that faced its older sister science, physics, more than half a century ago—this necessity of denying "common sense."<sup>45</sup> p. 120

Psychiatry, too, is confronted with the need to abandon "common sense." Thus, "common sense" has assumed that insights gained from the psychoanalytic situation should be *directly* applicable to other situations, for instance to problems of child rearing or to the disposition of criminals in courts of law. Experience shows that this is *not* possible; so there is criticism, in turn, of psy-

choanalysis, parents or lawyers, and refusal to draw the obvious conclusion—which is that most psychoanalytic concepts make good sense in the psychoanalytic situation, but that their relevance in other situations is a matter for careful and critical judgment. Psychoanalysis is here used for purposes of illustration only. Similar considerations hold true for concepts developed and used in other settings, such as in the state hospital (“manic-depressive psychosis”), in prison (“the Ganser syndrome”) or in the military situation (“malingering”).

Attention is also called to the role that words that purport to “explain” (when, in fact, they merely “name”) play in psychiatry and in psychiatric nosology. The word “schizophrenia” is singled out as probably the most important of these words. Its secure place in the taxonomy of our discipline, it is suggested, interferes with a better comprehension of the data for which this word allegedly accounts. The notion of “schizophrenia” further lends itself to the creation of a reified picture of this disorder, so that we imagine it to constitute a problem similar to others with which we are familiar in medicine, such as poliomyelitis or arteriosclerotic heart disease. It seems more likely that instead of “schizophrenia” being akin to such serviceable models of “disease,” its common bonds are with such panchrestons as “protoplasm” in biology and “ether” in physics. If so, it is useless to search for the “cause” and “treatment” of the “entity” that will account for the phenomena now labeled “schizophrenia.” Rather, a better comprehension of the “real facts”—if the writer may be excused for this expression—will probably lead to the gradual disappearance of this word, whose function, like that of all panchrestons, is to fill a scientific void.

In closing, a thought that has occurred to the writer in reflecting on this subject will be mentioned. It seemed odd—however obvious it may also seem—that our officially accepted nosological system is such that everyone pays lip-service to it, but almost no one considers it satisfactory. Often one hears such statements as, “Nosology is a necessary evil,” or, “Nosology is the expression of the immaturity of psychiatry as a science.” Such utterances are misleading. There is no science without classification. What matters is whether the taxonomic system used is appropriate for the endeavor at hand. The present situation with respect to psychiatric nosology may be compared to posting a blind policeman on

a new superhighway and then expecting him to enforce the speed laws. The rules of psychiatric nosology are not only being constantly violated, but they are violated gleefully. Nowadays, a contemptuous disregard for the rules of nosology has even become a part of the cloak of psychiatric authority.

An interpretation of this mode of social behavior would prompt one to assume that psychiatrists behave as if their system of nosology was created by "alien others" for no purpose other than to hinder them. Few feel sufficiently identified with this cause to do work along this line or to inspire their colleagues to change their ways. Yet, if one wants to work, all will agree that social order is better than anarchy. Similarly, nosological order would be better than the nosological anarchy which is our present state.

#### SUMMARY

The thesis of this essay is that most problems of psychiatric nosology, as currently formulated, are refractory to solution because of certain basic ambiguities in psychiatric concepts and operations. Scientific clarity and progress in this area depend upon clear agreement on the following issues:

1. The scope and subject matter that is to be designated as "psychiatry" (brain, mind, or behavior).
2. The scientific and technical methods that characterize this branch of knowledge (physics or psychology, physicochemical techniques or psychotherapy).
3. The precise nature of the phenomena that one seeks to classify (physical or chemical changes in the brain, social behavior, or behavior toward specific individuals).

These are not three separate categories, but represent rather interlocking aspects of what must be, in the last analysis, operational descriptions of specific "psychiatric situations."

An operational analysis of the chief psychiatric situations with which we are familiar today is briefly sketched. These include the mental hospital, private psychiatric practice (including the psychoanalytic situation), the child guidance clinic, the psychoanalytic training system, military service, the court of law, and prisons. A similar analysis is presented of the psychiatric situations which characterized the work of each of the principal figures in the history of psychiatry since Kraepelin.

This operational mode of approach suggests the need for a more "relativistic" view of psychiatry, by which is meant the appreciation that different observational methods imply differences in the very nature of the "material" observed. Thus, global approaches to psychiatry may have to be abandoned in favor of more limited, and socially and methodologically better-defined, plans of attack on specific problems. It is further inherent in this line of thought that a nosological system developed in, and appropriate to, one type of psychiatric situation cannot be validly transferred to another, radically different, psychiatric situation. This is a principle familiar to us from other branches of science and technology and from the various systems of classification that they employ.

Considerations of nosology also prompt a scrutiny of the specific items that are classified. The commonest and at present probably the single most important diagnostic label in psychiatry is "schizophrenia." Some epistemological aspects of the problem of schizophrenia are briefly discussed, and it is suggested that this word may now be functioning as a "pandhreston" (or "explain-all") which, instead of illuminating, obscures the essential problems that face psychiatry today.

In conclusion, some observations are offered on the currently widespread disregard of nosological rules by psychiatrists and the inhibiting influence of this disregard on progress in psychiatry.

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## THE TREATMENT OF SCHIZOPHRENIC OUT-PATIENTS WITH PROMAZINE AND RESERPINE\*

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This is a report on the study of schizophrenic out-patients in ataractic treatment. Considerable information has been accumulated on the ataractic treatment of in-patient psychotics. On the other hand, the information on out-patient treatment remains sparse. This study of schizophrenic out-patients is concerned with two questions: 1. Does ataractic treatment achieve continuing control of symptoms? 2. Does ataractic treatment induce behavioral toxicity, in the sense of diminished drive, activity level, or range of interest?

Two ataractics were compared, promazine and reserpine. The ataractic treatment was compared to a placebo period using the individual patient as his own control. The various factors within the field of psychiatric change were studied through objective rating scale criteria. The present observations extend through seven and a half months of ataractic treatment. It is planned to have the treated patients carried for several years in out-patient treatment.

### I. METHODOLOGY

#### *Patients*

All patients had primary diagnoses of schizophrenia. A majority had histories of hospitalization within the year preceding treatment. Of the 35 patients studied in the psychopharmacological clinic, 16 had been admitted immediately after discharge from a psychiatric observation ward, and 21 had been referred from a mental hygiene clinic. A description of the patients on the basis of psychiatric ratings suggests a chronic adaptation to psychopathology; that is, few gave evidence of hallucinations, delusions or acute agitation, whereas a majority were characterized by severe paranoid thought processes, obsessive thinking, and affective withdrawal.

\*This study—from the Psychopharmacological Research Unit and Clinic, Department of Psychiatry, State University of New York, Downstate Medical Center, Brooklyn—was supported in part by a grant from the Wyeth Laboratories, Radnor, Pa. Promazine was supplied as Sparine by the Wyeth Laboratories.

Of 139 patients admitted to the psychopharmacological clinic over an eight-month period, 85 "survived" a baseline placebo period (q.v.); and 60 of these were still active at the time of preparation of this report. Seventeen had dropped out spontaneously,\* and eight were rehospitalized. Of the 60 remaining patients, only 35 had received active treatment of at least two months, 20 with promazine, 15 with reserpine. The major part of this report will be focused on the course and outcome of treatment with these 35 patients.

At the time of the last evaluation, 35 patients had received from two and one-half to seven and one-half months of promazine or reserpine treatment (exclusive of the initial placebo period), with a median treatment duration of five months.

The promazine and reserpine groups were closely matched in terms of age and sex. The mean age for both groups was 29.8; and 40 per cent of the promazine patients and 53 per cent of the reserpine patients were males.

#### *Treatment Procedure*

After admission to the clinic, all patients were placed on a three-to-four week "placebo" period—to be followed by the period of drug administration. Thus the method of study was the "own-control" procedure, comparing a patient's status during a no-drug period with his later status on active medication. This method may have been costly in that it facilitated drop-out; but it was fruitful in differentiating placebo effects from drug effects in the same individual. The own-control method also has the advantage of comparing the patient with himself rather than matching him with another patient group. Matching of patients is a very difficult task when dealing with a schizophrenic population, because of the heterogeneity of this group of patients.

Patients were assigned randomly to either promazine or reserpine groups. The method of drug administration was single-blind. The patient was told on intake that he was receiving "one of the newer tranquilizing drugs" but was not told its name. The doctor

\*A major problem in out-patient treatment is that of drop-out. During the initial three-week placebo period, the drop-out rate tends to be higher than during the later drug treatment. Many of the writers' patients were not on active drugs at the time their drop-outs occurred, and the possibility exists that an earlier use of medication might have reduced the drop-out rate. It would also seem that if ataractics are to reduce drop-out from out-patient treatment, the speed of the drug effect becomes a major consideration.

was free to determine the dosage level, but a policy of achieving only "fractional tranquilization" was established, and dosage levels were relatively low. The range for promazine was 50 to 400 mg. daily, for reserpine  $\frac{1}{2}$  to 4 mg. daily. The majority of promazine patients received less than 200 mg. a day; the reserpine patients less than 2 mg.

Frequency of clinic visits was as follows: weekly, during the baseline period and first month of active treatment; bi-weekly, during the second month of active treatment; and monthly thereafter. In cases of urgency, a patient was free to consult his doctor between scheduled visits. Psychotherapy was avoided but was offered where circumstances seemed to demand it. In spite of the primary orientation toward medication, the clinic was not simply a pill-dispensing unit. One cannot discount the incidental psychotherapeutic effects stemming from a patient's regular 30-minute interview with his doctor. Any drug effect must be viewed in the context of a supportive doctor-patient relationship and a supportive clinic structure.

#### *Patient Evaluation*

Three forms of patient evaluation were employed by the psychiatrist:

1. At critical intervals (at intake, at the start of the drug, at a month after the drug started, and at three months after the drug started) major evaluations were made, involving the use of a 54-item rating scale, the "Psychiatric Rating Scale" (PRS).

The PRS seeks to evaluate such matters as the patient's affect level, activity level, thought organization, and the assessment of his interpersonal relationships. Of the 54 items in the scale, 39 were taken from the Lorr scale<sup>1</sup> and 15 items were added to these. The latter group of items had particular bearing on the outpatient situation, dealing with such problems as treatment motivation and the patient's attitude toward his mental illness. The 54 items are grouped into 16 factors, six derived from Lorr's empirical factors and 10 based on a priori groupings.

2. An "Abbreviated Clinical Rating Scale" (ACRS) was completed by the psychiatrist after all visits.

This ACRS is a 15-item psychiatric rating scale, dealing with major areas of psychopathology as well as with the patient's accessibility to communication and an estimate of prognosis. Because of its brevity, this scale could be filled out frequently, and it provided a longitudinal picture of the psychiatric course of treatment.

3. As a final measure, a "Comparative Global Evaluation" was made at the latest visit of the patient.

The doctor, with his original intake write-up in his hands, was asked to make a comparative judgment with the patient's current status. This comparative judgment was expressed on a rating scale ranging from "definitely worse" to "definitely improved." The psychiatrist was then asked to state in a descriptive paragraph the reasons for his judgment. This procedure was used to arrive at a *unitary* criterion of improvement (factorial rating scales tend to yield multiple and often contradictory indices of change). The Global Evaluation was used to ascertain that patients *have* changed; the Psychiatric Rating Scale was used to delineate the extent and areas of this change.

## II. TREATMENT OUTCOME

The Comparative Global Evaluation ratings for all 35 patients who had received two and a half months or more of active drug treatment (three months of clinic attendance) are presented in Table 1. The ratings of the two drugs are similar. "Definite im-

Table 1. Comparative Global Evaluation Ratings For Promazine-Treated and Reserpine-Treated Patients

	Promazine		Reserpine	
	N	Per cent	N	Per cent
Definitely worse .....	1	5	0	0
Slightly worse .....	0	0	0	0
No change .....	2	10	2	13
Slight improvement .....	9	45	6	40
Definite improvement .....	8	40	7	47
Total .....	20	100	15	100

provement" was shown by 40 per cent of the promazine patients and 47 per cent of the reserpine patients. When the "slightly-improved" patients are included, 85 per cent of the promazine patients and 87 per cent of the reserpine patients showed some kind of improvement. As will be evident in the following, the combining of the slightly-improved and definitely-improved patient groups must be viewed with extreme caution, and its validity is doubtful. In terms of over-all clinical effectiveness, the two drugs appear to be equivalent when given over a sufficient period.

### *Areas of Psychiatric Improvement*

In an attempt at delineating specific areas of psychiatric im-

provement for the 35 patients, mean factor ratings on the PRS were compared for the pre-treatment and the last evaluations.\*

Three of the 16 PRS factors showed significant changes. Mean pre-treatment and last evaluation scores for the three factors are presented in Table 2. The data show an *increase* in warmth in interpersonal relationships, a *decrease* in paranoid projection, and a *decrease* in affective withdrawal (apathy and neglect). It would appear that changes were observed involving reduction in pathological thought processes and facilitation of greater social participation; that is, less affective withdrawal, greater responsiveness, and "warmth" in the interview situation.

#### *Extent of Psychiatric Improvement*

In Table 2, one can also observe the extent of change in the three factors just discussed for patients rated as *definitely improved*, and for patients rated as *slightly improved* on the Comparative Global Evaluation. The significance of the changes in the three factors, as observed for the entire group, appears to be

Table 2. Mean Psychiatric Rating Scale Factor for Pre-Treatment and Last Evaluations

Psychiatric Rating Scale Factor	Global Improvement Rating					
	All Patients (N=35)		Definitely Improved Patients (N=15)		Slightly Improved Patients (N=16)	
			Pre-Treatment	Last Evaluation	Pre-Treatment	Last Evaluation
"Warmth" .....	2.26	2.51*	2.45	2.83**	2.22	2.34
Paranoid Projectivity ....	1.72	1.46*	1.45	1.17**	1.91	1.73
Affective Withdrawal ....	2.20	1.97*	2.03	1.80**	2.25	1.16

\*Mean difference:  $t > .05$

\*\*Mean difference:  $t > .10$

supported by the greater changes in these factors in the patients rated *definitely improved* (but only at the .1 level of confidence). There thus appears to be some corroboration of the impression that patients rated as *definitely improved* on the Comparative

\*The ratings for promazine-treated and reserpine-treated patients showed no observed differences in the factors of change. The two groups are considered together because of this.

Global Evaluation also have changed on the foregoing three factors. On the other hand, for the slightly improved patients, none of the differences between the pre-treatment and last evaluation even reach the .10 level of confidence. Corroboration is thus lacking of a specific change for patients rated *slightly improved*, and it appears doubtful that such a change has taken place in these patients.

The apparent corroboration of the Comparative Global Evaluation by the factorial ratings for the definitely improved patients, and the lack of corroboration for the slightly improved patients is of methodological interest. This finding stresses the importance of obtaining numerous criteria of change for the same patient. When these several criteria are mutually supportive, there is greater confidence that a change has taken place than when such criteria are not congruent. The "definitely improved" cases are regarded as having improved, but the other changes are considered unreliable. Absence of mutually supportive indicators of change may explain the wide variability of improvement ratings that have been found in the literature; these range from 20 per cent to 90 per cent.

#### *Distinguishing Drug Effect from Placebo Effect*

The investigation, as has already been noted, used the own-control method rather than the other-control method. Inasmuch as patients were started on an active drug only after an initial three-week to four-week placebo period, one could observe variations in the patient during the placebo period, during the active drug period, and over the entire span of treatment. For 24 of the 35 patients, there were Psychiatric Rating Scale evaluations at the following observation points: (a) intake, (b) end of placebo period, and (c) end of last treatment period. By observing a change between these observation points, one can delineate improvement primarily occurring during placebo administration (a vs. b), during drug treatment (b vs. c) or over the combined treatment period (a vs. c).

Table 3 lists the three PRS factors for the three observation points. The change on the first factor, warmth in interpersonal relationships, seems to take place during the placebo period exclusively. The two other factors, paranoid projectivity and affective withdrawal, show no change during the placebo period, but do

Table 3. Mean Psychiatric Rating Scale Factor Scores for 24 Patients Observed Under Three Treatment Conditions

Psychiatric Rating Scale Factor	Mean PRS Rating for			t Value for Comparison of PRS*		
	(a) Intake	(b) End of Placebo	(c) Last Evaluation	a vs. b	b vs. c	a vs. c
"Warmth" .....	2.25	2.50	2.40	2.42*	n.s.	n.s.
Paranoid						
Projectivity .....	1.69	1.73	1.36	n.s.	3.25**	2.27*
Affective						
Withdrawal .....	2.33	2.35	2.08	n.s.	2.70†	2.78†

For 23 d.f.: \*t .05=2.07

\*\*t .02=2.50

†t .01=2.81

show a change during the active treatment period. It appears that patients show no response to the placebo but do show response with medication in these latter factors, which are more intrinsically related to the pathological process.

#### *Speed of Drug Action*

One aspect of drug effect that the writers considered important in the treatment of schizophrenic out-patients is the speed of action. It has been observed in in-patient studies that Rauwolfia derivatives show a slower onset of action than do the phenothiazines. Does one find a similar difference in the case of out-patients?

Two ways of gauging the speed of drug effectiveness may be used: (1) the rate of drop-out after active medication has been started; and (2) the time required for improvement to be observed among patients who later show improvement.

Using the time of drop-out as the criterion for speed of action, the number of weeks elapsing before drop-out took place was determined. The drop-out patients referred to here are patients who "survived" the three-week placebo period. Table 4 shows that after two weeks of active treatment, five reserpine patients had dropped out, whereas only one promazine patient did. After six weeks or more of treatment, the rates for the two groups were about equal; nine and eight patients, respectively, had dropped out.

Another way of studying the speed of drug action is to observe the timing of psychiatric improvement. Fifteen patients (eight on promazine and seven on reserpine) were selected who showed

Table 4. Weeks of Active Treatment Elapsing Before Drop-Out Occurred for Promazine-Treated and Reserpine-Treated Patients

Weeks of Drug Treatment Before Drop-Out	Promazine	Reserpine
1	1	0
2	0	5
3	2	0
4	2	2
5	0	0
6 or more	4	1
Total	9	8

definite psychiatric improvement after at least two months of treatment. For each patient, a focal symptom was defined—the one that had shown the severest pathology before drug treatment and which later showed the greatest improvement at the time of final evaluation. This symptom was traced on the ACRS reports which had been filled out at each visit.

The mean improvement (relative to the pre-drug rating of the focal symptom) for the patients in the improved promazine and reserpine groups was studied for a 12-week-span.\* It was found that, at two weeks of treatment, 29 per cent of the reserpine patients who later definitely improved showed improvement in the focal symptom (based on two of seven patients showing at least some improvement), whereas the figure for promazine patients was 63 per cent (based on five of 8 patients showing at least some improvement during the initial two weeks of treatment). On the other hand, when these patients had had six weeks of ataractic treatment, no difference in improvement between promazine-treated and reserpine-treated patients was observed, and the level of improvement which was later maintained had been reached. In these 15 patients, the improvement was sustained for at least 12 weeks of drug treatment.

The foregoing trends suggest that about six weeks of treatment is required for the drugs to reach equal effectiveness. There is clinical evidence (although not statistically reliable) suggesting greater speed of action for promazine than for reserpine. Promazine appears to help to prevent drop-out early in treatment, and psychiatric improvement appears to occur earlier.

\*This improvement amounted to 1 or 2 points for each patient on the 4-point scales of the ACRS.

### *Side Reactions*

The most common side reaction observed was drowsiness, which was seen in nine (60 per cent) of the reserpine cases, and eight (40 per cent) of the promazine cases. Other side reactions that occurred to a significant degree were nasal congestion, seen only with reserpine (three cases), gastro-intestinal discomfort, seen only with promazine (three cases), and dizziness, seen both with promazine (two cases) and reserpine (one case). The other side reactions (jitteriness, arthralgia, decreased libido, depression, increased appetite, tachycardia) cannot be judged significant, in view of their low incidence in a small total of cases.

Interestingly, some characteristics of the side reactions with promazine were related to psychiatric improvement. Patients who eventually showed definite psychiatric improvement on promazine tended to show side reactions which were specific for the drug but transitory in nature. These patients showed no reactions during the placebo period but did have slight drowsiness or dizziness for the first two weeks of active drug treatment. On the other hand, patients who did not improve or who improved only slightly on promazine tended to show either no side reactions at all or had multiple reactions, beginning in the placebo period and continuing through the course of drug treatment. Five of the patients on promazine who showed these multiple continuous side reactions were in the nonimproved or slightly improved groups; none of the definitely improved patients showed such reactions. Continuous nonspecific reactions may be regarded as nonadaptive responses to drug intake. On the other hand, specific, transitory side reactions associated with definite improvement may be regarded as adaptive somatic reactions to drug intake.

In the series there was no occurrence of jaundice, seizures, dermatological reactions, parkinsonism or agranulocytosis. Total leucocyte counts were made at intervals while the patients were on active drug therapy. Leucopenic reactions (white blood cell count below 5,000) were noticed in three of the promazine cases, but in none of the reserpine cases. There were no serious clinical consequences in these leucopenic reactions.

### *Rehospitalization*

Of the eight patients requiring rehospitalization, three were on promazine, five on reserpine. Of the three rehospitalized proma-

zine cases, two had received less than a month of the medication, and the third had had a two-month period on the drug. Of the five rehospitalized reserpine patients, two were in treatment two weeks or less. The reasons for rehospitalization were: (1) a strong suicidal potential; (2) a homicidal threat, and (3) increased agitation, threatening behavior, and anxiety associated with upsurging of paranoid ideation.

In the case of these treatment failures, the relatively low dosage levels geared toward the maintenance of chronic patients may not have been adequate for these more agitated patients.

### III. DISCUSSION

In considering observations on drug effects, a basic question must be considered: Were the changes observed specific to the drug treatment, or could they be attributed to other factors, for example, the doctor-patient relationship? Two observations suggest that the changes reported here are due to a drug effect:

1. The procedure permitted delineation of changes attributable to the placebo period only and to the drug period only. The changes observed during the drug period dealt with areas which are intrinsically related to the pathological processes (reduction in paranoid projection and withdrawal). On the other hand, the behavior change during the placebo period (in the absence of drugs) was closely related to events occurring in the doctor-patient relationship (greater warmth). An objection may be raised that the drug period was longer than the placebo-control period; hence that there was more opportunity for improvement to be observed during drug treatment. However, it was observed that improvement when it took place, occurred after two to three weeks of active drug treatment.

2. Psychiatric improvement was associated with specific somatic reactions to the drug.

The findings noted in this paper, of the effectiveness and specificity of action by promazine and reserpine in the treatment of schizophrenic out-patients brings up the question of ataractic effects on psychopathology. In the group of chronic patients treated, in whom the pathological picture lacks such symptoms as agitation and manifest anxiety, one target of treatment becomes the mode of pathological thinking, that is, the aim is reduction in paranoid projection. Judging from the Psychiatric Rating Scale

items, drug-treated patients felt "less talked about," "less watched," and "less influenced or controlled." The threat-content of the environment had been reduced. Stimuli which the patient previously sensed as dangerous to himself were made ineffective. This threat reduction may be viewed as an aspect of the inhibition of fear reactions observed with ataractics on an autonomic<sup>2</sup> and overt behavioral level.

The decrease in withdrawal and apathy found in the present study has been less commonly observed elsewhere. In terms of the Psychiatric Rating Scale items, patients were observed to show "more concern" and less indifference about their environment. This greater concern was also reflected in a greater effort toward maintaining a socially acceptable physical appearance. Patients were seen to be less sloppy, less unkempt, and to exhibit a wider range of interest in the environment. Such changes are of obvious practical clinical value. They suggest that tranquilizing drugs, such as promazine or reserpine can contribute to more effective social participation and rehabilitation of chronic schizophrenics.

The decrease in affective withdrawal is more difficult to interpret theoretically. Is the decrease of withdrawal a function of the same reduced anxiety that is considered responsible for the decrease in paranoid thinking? This might be true if the withdrawal were considered to be a response to strong underlying anxiety. However, many of the patients who showed decreases in withdrawal gave no outstanding pre-treatment signs of anxiety. Moreover, improvement in paranoid ideation, and reduction in withdrawal were uncorrelated. Whereas some patients showed reduction in paranoid projection, different patients became less withdrawn. The answer appears to lie elsewhere than in the problem of anxiety.

Physiological experiments have shown that both phenothiazine and Rauwolfia derivatives have not only inhibiting properties (for inhibition of the fright-flight reaction) but also have alerting and possibly stimulating properties related to their effect in activating the meso-diencephalic system. These drugs show both an absence of sleep pattern in the EEG and lowering of the convulsive threshold.<sup>3</sup> One may suppose that this physiological state of alertness may lead to receptiveness to the communicative influence of the environment. In a previous ward study with disturbed psychotic patients, promazine and chlorpromazine were given in doses

of 800 to 1,000 mg. daily. Here, symptom control was associated with an increase in withdrawal. In the present study, it was frequently noted that a patient showing no response to promazine in doses of 350 to 400 mg. would respond when the dosage was reduced to 150 mg. At these lower dosage levels, one may speculate that the inhibiting drug effects are less pronounced and the alerting actions permitted to emerge.

#### IV. SUMMARY

This is a study evaluating the psychiatric effects of promazine and reserpine on schizophrenic out-patients. Specifically, it was sought to determine whether these drugs achieved control of pathological symptoms and whether they would induce behavioral toxicity, that is, diminished activity, drive level, or range of interest. Thirty-five patients, 20 on promazine and 15 on reserpine, who had from two and one-half to seven and one-half months of ataractic treatment were studied. The findings were:

1. Both promazine and reserpine are effective in the care of chronic schizophrenic out-patients in the context of a supportive doctor-patient relationship. Statistically significant changes in the patients' psychiatric condition occurred during drug treatment and were not observed during an initial placebo period.

2. Patients treated with promazine and reserpine showed significant declines in pathological thinking, particularly in the area of paranoid projectivity.

3. Promazine and reserpine patients gave evidence of decreased withdrawal and apathy.

4. The median dosage levels at which these changes were observed were 150 mg. daily for promazine, and 2 mg. daily for reserpine. These relatively low doses may be responsible for the type of improvement observed. This improvement includes both the control of pathological thinking and the facilitation of greater social responsiveness. However, for patients with symptoms of agitation or strong aggressive urges initially higher doses may be necessary. The effect achieved at these lower dosages appears qualitatively different from that achieved at a higher dosage.

5. In comparison with reserpine, promazine appears to be a fast-acting drug. This speed may contribute to holding the patient in treatment, that is, preventing drop-out and cementing the doctor-

patient relationship. After six weeks of treatment had elapsed, however, the holding and therapeutic action of reserpine was equal to that of promazine.

6. The quality and timing of somatic side reactions in this study are related to the effectiveness of promazine treatment. Transient side reactions specific to the drug (rather than to a placebo) were associated with eventual psychiatric improvement.

7. No serious side reactions were observed with promazine or reserpine.

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## ADVANTAGES OF THE CONCEPT OF A CONTINUUM OF SCHIZOPHRENIC REACTIONS\*

BY JOSEPH D. LICHTENBERG, M.D.

Psychiatrists for years have considered that there either are two separate types of illnesses, psychogenic schizophrenia and "process schizophrenia," or that it is a single illness of varying severity. This latter notion has been advanced by Leopold Bellak<sup>1</sup> as a concept that there is a "psychosomatic" continuum of schizophrenic illnesses with the psychic causes at one end and the somatic causes at the other. In everyday practice, many clinicians, whether agreeing or not with Bellak's etiological premises, work operationally with an entirely different set of propositions about a continuum. These propositions are derived from clinical observations of large numbers of patients and are based on what might be called potentials for recovery. These premises assume that there is a continuum which runs from those schizophrenic patients who will recover spontaneously from a psychotic state to a nonpsychotic state, to those who will not be able to recover, regardless of any present mode of treatment.

In this paper, the patients who recover spontaneously will be referred to as Group I, and those who fail to recover regardless of therapy will be referred to as Group III. Between these two groups are large numbers of patients with varying degrees of potential for recovery, Group II. These premises and the conceptual framework they provide are rarely stated explicitly. As a result, the inexperienced psychiatric resident often suffers confusion and disappointment when he, for example, attempts to apply the modifications of psychoanalytic treatment proposed by such people as Hill<sup>2</sup> and Fromm-Reichmann<sup>3</sup> inappropriately to patients at the Group III end of the spectrum. In using the patients' potentials for recovery as criteria, patients can be grouped on a continuum in a way that allows an understanding of what is an appropriate therapeutic goal for each group and of how current treatment methods can be used to achieve that goal. However, since there actually is no way to determine specifically a given patient's potential for recovery, the clinical concept of a continuum referred to in this paper is one obtained from reasoning

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backward from clinical experience (with patients who have or have not recovered). It is the purpose of this paper to state, using case histories, the clinical information the writer now uses to group patients. The advantages and limitations of these commonly used clinical propositions will then be considered.

Group I patients typically have acute onsets of illness, marked by confusion and considerable affect following relatively severe stress. They have backgrounds of occupational accomplishments, of forming close workable personal relations, and of demonstrating some flexibility in their dealings with people and with life situations. Usually, chronic stress in their living conditions is either not very great or, at least, is potentially alterable. Under the protective, benevolent care of a hospital, these patients become less confused and simultaneously form an active and relatively realistic relationship with the people caring for them. Gross psychotic manifestations gradually disappear entirely. Healthy elements of such a patient's personality are not appreciably weakened as a result of the experience, since there is no subtle invasion by the psychotic process.

#### *Case 1*

At the time of her second hospitalization, Mrs. L. was 39 years old.\* She lived with her family, of extremely poor Italian immigrants, until her father died when she was four and she was adopted by a childless, wealthy, midwestern couple in their forties. She was raised by a governess, since her adoptive mother was never fond of her. She made the adjustment to the upper class society of her adoptive parents fairly well, though she had occasional histrionic outbursts. She did well in school, traveled in Europe, made friends, and married a personable man while in college. The patient had two daughters in the early years of her marriage and raised them without difficulty.

As the years went by she and her husband drifted apart as he became more engrossed in business and civic activities. She prayed for a male child as a way of reawakening his interest. Four months after the birth of a boy, the patient became acutely disturbed when her husband was away on a trip with their two daughters. She was hospitalized and showed spontaneous marked improvement, but was signed out of the hospital prematurely after three months without any psychotherapy. The family at first was more integrated after this but the members gradually pulled apart, each going his separate way. The patient had little insight into her feelings about her son, was unable to discipline him, and was so dimly

\*Case material obtained from the records of the Sheppard and Enoch Pratt Hospital.

aware of her feelings about her husband that she was unable to make her wishes known. More and more involved in trying to "lead her own life" to show her husband she could be as busy as he, she became acutely psychotic four years after her first illness.

On admission, she was catatonic. Within a month her psychomotor retardation lessened spontaneously and without specific treatment; and her confusion, hallucinations and delusions disappeared. She was able to establish a relationship with her therapist without undue dependency, and she used this relationship to participate willingly in an investigation of her present conflicts and some of their antecedents. She was able to make plans with her husband about changing their pattern of living, and was discharged in five months. She continued psychotherapy as an out-patient, has been able to organize her life better, is generally less tense, and is more comfortable with her son.

Group II, the middle area of the continuum, is made up of a large number of patients having the potentiality for varying degrees of improvement. These patients range from those who can respond to treatment with almost complete recovery, to those who show persistent symptoms. The patients near the Group I end have a history of successful human and business dealings, and more readily relate to the people who care for them. The patients near the Group III end have a more insidious onset and relate to people slowly, tenuously and painfully. They function only in a dependent situation and tend to have repeated episodes of illness.

#### *Case 2*

At the time of her hospital admission Mrs. A. was 30 and the mother of three children. She came from a prominent and successful family, had attended private schools and was president of her graduating class in college. She married at 22, although her family disapproved of her husband because he had not attended college—in spite of the fact that he had attained the rank of major during World War II. The patient was an obsessive housekeeper and parent. The onset of her illness followed a period when she nursed her family through influenza, while at the same time her husband suffered financial reverses, due in part to his own negligence.

She was acutely disturbed, confused, hallucinated, delusional, fearful, and preoccupied with religious and self-depreciatory ideas. After two months of disturbed behavior she was started on insulin coma therapy, followed in two weeks by lessening of symptoms. She had 47 comas with almost complete disappearance of all psychotic manifestations. During the latter part of her insulin therapy, and for two months thereafter in

the hospital, she actively participated in an examination of her too close relationships with her mother, her feelings about her husband in respect to her mother's disapproval and interference, and her own feelings about her husband's negligence. She also came to see her traditional role as family peacemaker. The patient continued intensive therapy for a period after leaving the hospital.

### *Case 3*

B. was 24 at his second hospitalization. Both his paternal grandmother and his mother had committed suicide. His early life had been marked by instability—his father lost his money, his parents were unfaithful to each other, his mother became a severe alcoholic and drug addict. The patient lived with his mother at times, with her parents at times, and in private schools at other times during the mother's many hospitalizations prior to her suicide when he was 15. He was always reserved and tense, and had a spotty school record. He was pushed by his family's ambition for him to be a member of his father's fraternity at his father's college, and to be a doctor. Without specific immediate stress, he became gradually disturbed during his second year of college until, by the time of his first hospitalization, he was tense, delusional, generally retarded, and occasionally excited.

He made a slow stormy, partial recovery over 15 months with narcotherapy and supportive daily management. He left the hospital still committed to try to follow a college program. He was stabilized for a time on routine jobs, and then worked 14 hours a day, six days a week, while attempting to take college courses and to gain managerial recognition at his job. He again became severely disturbed and was hospitalized. His second hospitalization lasted eight months, with termination of his disturbed episode by ECT. His previous goals were reviewed with him; and, after much reluctance and a period of depression, he relinquished them. He has made a good, dependent adjustment at a simple job, with continued active psychiatric support.

For the Group III patients, the onset of illness is usually insidious, and there is frequently poor scholastic or occupational history. The immediate stress is often slight, and the psychotic process follows the collapse of an untenable life situation based on dependency and/or its denial. These patients show persistent regression and either general loss of outward drive, or loss of the ability to control its discharge. The psychotic process tends to pervade the whole personality. Within this group there are patients who become acutely ill and who have backgrounds of considerable achievement. They have histories of rigid obsessiveness,

fail to make close friends, and lack the flexibility to deal with loss of prestige.<sup>4</sup>

#### *Case 4*

Miss O. was 16 at the time of her admission to Sheppard and Enoch Pratt Hospital. Her family were middle class people who tried carefully to train the patient to do "the right thing." The patient was a coddled and obese infant who had intractable eczema when she was aged two to five. At seven or eight, she was extremely insecure and self-centered. She spent most of her time daydreaming and dancing in front of a mirror, was in frequent difficulty at school and had no close friends. After her confirmation at the age of 15, she became more highstrung and "nasty" and had frequent tantrums. She gradually became more assaultive and finally frankly psychotic.

In the hospital she was hallucinated, was mildly confused, coy, and petulant, extremely childish and preoccupied with thoughts of being a "bad girl" and "a freak of nature." Throughout the several years of hospitalization to date these symptoms have more or less persisted unabated, with occasional excitements and slight improvements following sleep therapy, insulin coma therapy, electric convulsive therapy, and chlorpromazine. She has responded to nursing care with some lessening of severe regressive behavior, keeps her clothes on, feeds herself, and no longer masturbates openly.

#### *Case 5*

R. is 23. He was a "model" student and son, his mother's favorite and a boy regarded as the nicest and brightest in the neighborhood. His manners were perfect, as were his grades. When he was 12 and a half years old he had an episode of spinal meningitis, following which he was sent to military school to improve his posture. There he continued his brilliant scholastic record, and he played football in spite of a very slight frame.

In his first year at college, however, he failed to get into the "best" fraternity, and shortly thereafter developed ideas of reference and was acutely psychotic. He received insulin and ECT with some temporary improvement of his mute catatonic state. For a year before his hospital admission, he was mute and required tube feeding twice a day. On reserpine, and with active nursing care, he now feeds himself, dresses and goes outside for walks, in spite of persistent waxy flexibility.

The advantages of the use of the concept of a continuum based on potential for recovery are:

1. It is a more practical working concept than one based, as is Bellak's, on etiology, because in work with patients it is not only difficult to establish the presence of an organic cause, but, if one is established, it is generally impossible to measure and

evaluate the extent of its influence. It has the further advantage that if Bellak's multiple etiological factor theory can be proved, the two frames of reference (the etiological and the potential for recovery) would very likely coincide.

2. It offers a way of understanding the changes in improvement rates and the effects of various total push programs.

3. It allows for a rational approach to the setting of therapeutic goals and provides criteria for the use of different forms of treatment to achieve these goals.

When the improvement rates for schizophrenic illnesses are examined, the outstanding facts are:

1. Before the introduction of such specific treatment techniques as physical and chemical therapies, significant numbers of patients showed definite improvement. (Typically, reports of individual institutions<sup>5-8</sup> showed improvement rates of between 32 and 44 per cent. Neumann and Finkenbrink<sup>9</sup> found an improvement rate of 32.9 per cent in a review of 4,254 cases.) This lends support to the existence of Group I—patients who recover spontaneously.

2. With modern treatment methods and total push efforts, improvement rates have increased. One of the highest reports of improvement rates in the era before 1935 was 44 per cent in a small private hospital, where individual care was given to 88 cases between 1931 and 1935. In the period following the advent of physical therapies, the New York state hospital system reports improvement rates of 57 per cent and discharge rates of 62.1 per cent over four years for 2,960 first-admission schizophrenic patients, admitted between April 1, 1944 and March 31, 1945.<sup>10</sup> These figures, plus those compiled by Kramer, et al.,<sup>11</sup> at Warren (Pa.) State Hospital, and those of Freyhan<sup>12</sup> at Delaware State Hospital, suggest that it has been possible to utilize the potential for recovery of more and more Group II patients. Further evidence that this is so can be presumed from the good results of the various total push programs. The writer believes that the patients who responded in the cases noted here were Group II patients for whom the kind of care needed to allow a favorable growth of the potential for recovery had not previously been available. The total push experiences<sup>13, 14</sup> can be seen then as a filter separating Group II patients, still hospitalized, from Group III patients.

3. Regardless of treatment methods a significant number of patients do not recover.

The main advantage the continuum concept has in daily practice is its usefulness in conceptualizing therapeutic goals and the choice of technique for achieving them. With Group I patients, the therapeutic goal is not only to accomplish a favorable resolution of the immediate psychotic break, but to work out, more or less intensively, the patients' characterological and situational problems by using their relatively high potentials for sustaining interpersonal relationships with a therapist.

Chlorpromazine and similar drugs may serve to shorten the length of a disturbed episode and, therefore, help a patient to become sufficiently well-oriented to his environment to begin an investigative therapy sooner. However, the unwise and ill-timed use of physical and chemical therapies, particularly electric shock, in Group I patients, may have exactly the opposite effect, by interfering with the patient's own self-regulating tendency toward spontaneous recovery, and by interfering in the process, with the formation of an active, useful relationship with the therapist. During at least the first few months of intensive psychotherapy, the background of a hospital setting is extremely useful as a controlled environment, against which both patient and therapist can see the patient's problems, and within which the patient can be assured of protection at times of upsurging tension.

In Group II patients, the tendency toward spontaneous recovery is weaker and the need for active intervention to terminate psychotic withdrawal is greater. Furthermore, it is frequently necessary to use some combination of active treatments as a kind of artificial support, maintaining integration, while the patient's own homeostatic devices regain a sufficient amount of their previous functioning. Thus, the physical and, now increasingly, the chemical therapies find their greatest usefulness with the patients in Group II. These patients—before the general improvement in hospital care and the advent of these treatments—tended toward prolonged, often permanently-incapacitating psychotic episodes. These seemed to be self-perpetuating, in that the long psychotic withdrawal frequently precluded making use of the patient's own potentiality toward sustaining available interpersonal relationships and returning to life in the community.

Increasing attention has been paid in recent years to the use of modified psychoanalytically-oriented techniques in the treatment of these patients. This type of help, so important as "insur-

ance" against repeated episodes, can be an integral part of the rational approach to the treatment of increasing numbers of Group II patients, often in combination with ataractic drugs. However, in the majority of large public hospitals, individual psychotherapy is not available for most patients, and the one-to-one type of doctor-patient relationship is not possible. In addition, many of the sicker Group II patients are not able to benefit from intensive exploratory psychotherapy. In such cases, the therapeutic milieu of the hospital becomes exceedingly important in that the teamwork and good will demonstrated by the hospital personnel can supply a mental image strongly in contrast to the patient's discouragement about human relations. The patients can then establish a relationship with the milieu which can be the psychic equivalent of a "good parent" introject. This may be embodied in the directing therapist or in the institution itself. For a large number of Group II patients, this can be the most important factor among those leading toward the recovery of ability to re-establish relationships with their families, friends and business associates. The patients' need for maintaining this mental image of the hospital, as a sustaining, supportive, parental introject, has given rise to an increased use of follow-up contacts—with out-patient clinics attached to the large public hospitals.

For the Group III patients, the creation of a milieu designed to fit their needs is often the difference between total regression and the ability to care for themselves. For this milieu to be successful, the needs of these patients for continuous dependency and support must be accepted. Verbal therapies are generally of little avail, and treatment goals must be very limited lest the patients be overloaded. For these patients the use of electric shock or insulin coma was extremely disappointing. Shock or coma might result in brief periods in which the patients were able to lay aside some bizarre symptoms of withdrawal; but such patients were not able to use the "lucid" interval to acquire the capacity for sustained relationship with the environment. They would soon withdraw again.

However, the ataractic drugs have been more successful in helping Group III patients to be more accessible to slow, long-range efforts at habit retraining. By recognizing where such patients belong on a continuum, one grasps not only what cannot be done, so that self-defeating goals are avoided, but also what can be done, so that efforts can be directed toward it. If one gives attention

and careful nursing care, and is willing to accept their dependency, these patients can be helped to clothe themselves, to handle their natural functions in a socially acceptable way and to maintain some social contacts with the environment.

Now, therefore, the major advantage for the clinician of the continuum concept—that it provides a way of organizing, in a sort of “handbook-guide” form, the varying treatment goals and methods for the great variety of patients whose illnesses are grouped together as schizophrenic reactions—has been outlined. However, one is now confronted with an obvious limitation of the value of this concept: It reasons backward from results to treatment methods, since it offers no real definition of its basic frame of reference—the potential for recovery. Another way of putting this difficulty is that there is as yet no answer to the question of where to place a given patient on the continuum.

In practice, what is done now is to use certain classical prognostic indications, as acuteness of onset, severity of stress, amount of affect, degree of confusion, plus the “workability” of the patient’s living situation. This prognostic study is coupled with an estimate of the patient’s “psychic economy” or “ego strength.” The main difficulty is that, at the present time, it is possible to make little more than a considered professional guess about this decisive factor, by using experience and intuition and the help offered by psychological testing. Thus, at the crucial point, one cannot validate one’s speculations or put them to use in deciding about a given patient. In spite of this, the author believes that the continuum concept is a valuable one because: (1) It offers a rational explanation for what is observed and done in everyday practice; (2) it provides a general framework within which new knowledge can be integrated; and (3) it focuses on the need for further research into what is meant by ego strength.

The author believes that there are at least two broad approaches to this all-important problem. The first is through understanding the economic factors of mental existence, and through defining and describing ego functions. Hartman’s<sup>15, 16</sup> work is very promising; and that of Beres<sup>17</sup> is particularly so. As one becomes better able to delimit individual ego functions, it will be possible to devise means of measuring them.

A second broad approach would be through a large-scale project in which a group of schizophrenic patients would be studied by

attempting to place them on the continuum. Various factors used in evaluation could then be checked with results; and one hopes that the more critical factors could be demonstrated. Clinical evaluations, by such means as Beck's technique,<sup>15</sup> and various schemas of psychological tests could be used in such a project. Of course, this is merely a very loose outline of an undertaking that would be difficult to devise and control. The author believes, however, that there are few problems as challenging and as much in need of solving as the final proof of whether there is indeed a continuum of schizophrenic patients and if there is, how patients can be placed on it.

#### SUMMARY

1. The common clinical usage of the concept of a continuum of schizophrenic reactions based on the patient's potential for recovery is described in this paper. This concept is that a continuum stretches between patients who have high potentials for spontaneous recovery from psychotic episodes (Group I) to those who have very few or no such potentials (Group III). Between these, are large numbers of patients (Group II), with varying potentials for recovery, for whom the chances of recovery have been enhanced in recent years with modern treatment methods.

2. The advantages of these groupings—for understanding the changes in improvement rates and the effects of various total push programs, and for understanding the rationale for the use of current treatment methods for patients at different points on the continuum—are discussed.

3. The obvious limitation of the value of this concept, that it reasons backward from results to treatment methods, is also discussed and the need is emphasized for better answers to the questions of how to decide where to place a given patient on the continuum.

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## THE ECOLOGICAL DISTRIBUTION OF PATIENTS ADMITTED TO MENTAL HOSPITALS FROM AN URBAN AREA\*

BY ROBERT H. HARDT, M.A.

### INTRODUCTION

The study of community variations in the proportions of residents hospitalized because of mental disorders has a long history. Some ninety years ago, Jarvis observed substantial differences in hospitalization rates between different communities and indicated that, in general, rates varied inversely with the distance between the community and the hospital.<sup>1</sup> The classic study of Faris and Dunham revealed that, within Chicago, area variations in the rates of hospitalization for mental disorder were associated with area differences in social and economic status.<sup>2</sup> Subsequently, other investigators conducted similar studies in several large American cities.<sup>3</sup>

As part of the general program of the Syracuse Mental Health Research Unit, a series of studies has been focused on area variations in hospitalization rates. Studies have been completed on variations in rates of cities in New York State<sup>4</sup> and of rural and urban communities within a single standard metropolitan area.<sup>5</sup> In a previous study conducted within Syracuse, certain environmental conditions were found to be associated with areas having high rates of first admissions to mental hospitals for the diagnoses of cerebral arteriosclerosis and senile psychoses (abbreviated to CASSP).<sup>6</sup>

An area was located "in the center of the city... characterized by high CASSP rates, by high concentrations of multiple family dwellings, and by high percentages of people living alone." The present report deals with the association between the same environmental conditions and area rates of first admissions of several additional diagnostic groups.

### DATA OF THIS STUDY

The data on the case population in this study have been obtained from records of first admissions to public and private

\*From the Mental Health Research Unit, New York State Department of Mental Hygiene, Syracuse, N. Y. Appreciation is expressed to S. Bellin, J. Downing, M.D., and I. McCaffrey of this unit for their helpful suggestions.

mental hospitals in New York State. The following items of information were obtained on all Syracuse residents who were admitted for the first time to these hospitals between 1935 and 1944: (1) sex, (2) age, (3) diagnosis, (4) street address listed as residence at time of admission. The majority of the first admissions were to two state hospitals which serve the entire city, so that the effects of possible variations by the hospitals in diagnosis were minimized. Using the 1940 census figures as a population base, citywide rates were computed by age and sex for the following diagnostic categories:

1. Cerebral arteriosclerosis and senile psychosis (CASSP)
2. Dementia praecox (DP)
3. Alcoholic psychosis (AP)
4. Manic-depressive and involutional psychoses (MDI)
5. Other and undiagnosed psychoses (OP)
6. Without psychosis (WP)

These rates and the number of admissions are presented in Appendix Table A. The abbreviations listed will be used in the rest of this report. An inspection of the rates for each diagnostic group revealed some variations between the sexes and wide variations by age. Therefore, it was considered desirable to compute tract rates for each sex separately and to define a high-risk age span for each diagnosis. First admissions within this age span were allocated to the census tract in which they lived at the time of hospital admission. A census tract is a small subdivision designed to be "fairly homogeneous in regard to population characteristics."<sup>7</sup> In the few instances in which the addresses were unknown, no tract allocations could be made.

For each tract, the average annual rate of first admissions was computed per 100,000 population within a specific age range. Furthermore, each of these rates was age-adjusted by the indirect method.<sup>8</sup> Nine tracts with small populations (less than 1,000) were excluded from the analysis. Also, the numbers of first admissions of male manic-depressives and female alcoholic psychotics were considered too small to detect significant variations among rates of the individual tracts. The age-adjusted tract rates of first admissions for each major diagnostic category are presented in Appendix Table B.

## METHOD

In the study of CASSP admissions, it was found that most of the census tracts consistently high in admission rates had: (1) an average of 2.25 or more dwelling units per structure; (2) and/or 4 or more per cent of their populations living alone; and (3) were either within or adjacent to a low socio-economic area.\* A considerable number of low socio-economic tracts, however, did not have high admission rates.\*\*

The three characteristics mentioned are viewed as presumptive risk factors, and will be referred to as "undesirable" environmental conditions. For the analysis of rate variations, the census tracts have been grouped into four major social area types designated by the numerals 3, 2, 1 and 0. The numerals represent the number of undesirable characteristics which are present. The geographic distribution of tracts which represent each type is depicted on the map.

The six tracts which comprise Area 3 include the central business district, and have all three undesirable characteristics. Area 2 consists of six tracts possessing two undesirable conditions. These tracts are contiguous with Area 3. All 18 tracts in Area 1 have low socio-economic status. Area 0 consists of 22 tracts having none of the undesirable conditions.

The arithmetic means of the first admission rates of the tracts within each of the areas have been computed for each of the 10 diagnostic-sex groups that had relatively large numbers of admis-

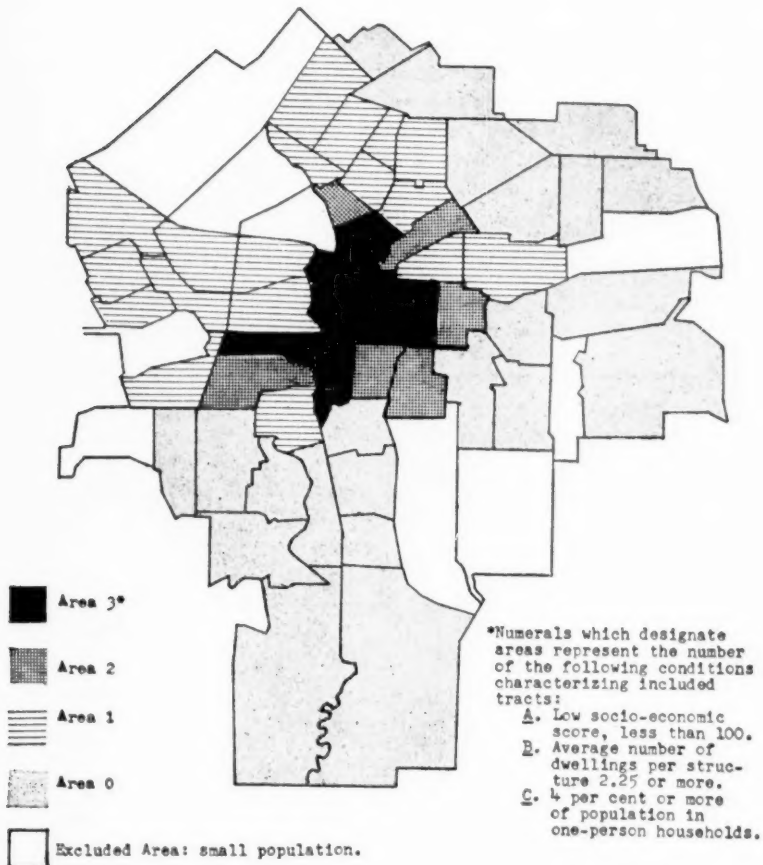
\*The particular socio-economic index used in this study was developed by C. V. Willie under a grant from the Milbank Memorial Fund (Ref 9). In this paper, tracts with index scores below 100 are referred to as low socio-economic tracts. The five components of the index are:

- (a) average contracted monthly rent;
- (b) average value of owned homes;
- (c) median school year completed by persons aged 25 years and over;
- (d) percentage of all dwelling units of single-family type; and
- (e) percentage of employed persons who were operatives, service workers, and laborers.

For each variable, tract measures were converted into standard scores by setting the mean value of the 59 census tracts equal to 100, and the standard deviation equal to 10. The tract index of socio-economic status is the mean of the five standard scores obtained by that tract. In these computations, two tracts were eliminated, one occupying unsettled land and another inhabited by residents of Syracuse State School (an institution for mental defectives).

\*\*For a brief discussion of the characteristics of these tracts, see McCaffrey and Downing, Ref. 10, p. 1064.

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sions. While this procedure was preferred,\* a different averaging method was necessitated for the two groups with relatively few admissions: females with alcoholic psychoses and males with manic-depressive psychosis. For these two groups, the area rates are based on the pooled or aggregated experience of the tracts within each area. Both types of mean area rates will be referred to as "area rates."

\*For a discussion of the merits of the distributive versus the aggregative approach, see Bogue and Harris, Ref. 11, esp. pp. 2, 3.

## FINDINGS

The four area rates are presented by sex for each diagnostic category in Table 1.\* To facilitate comparison of area differences, Table 2 represents these four area rates, expressed in ratio to the diagnostic-sex specific rate for the entire 52-tract area included in the study. A ratio above 1.00 indicates that the area rate is higher than the 52-tract rate, while ratios below 1.00 signify that the area rate is lower than the 52-tract rate.

Some caution must be observed in considering the area rates, and consequently the rate ratios, as typical of the tract rates within each area. Considerable rate variation occurs among tracts

Table 1. Average Annual First Admission Rates\* to Mental Hospitals in New York State by Diagnosis and Sex, for Census Tracts Grouped into Social Areas, Syracuse, N. Y., 1935 to 1944

Diagnosis	Age	Sex	Ave. Annual First Adm. Rate per 100,000 Pop.				
			52 Tracts	Area 3	Area 2	Area 1	Area 0
CASSP	65+	M	326	474	480	257	241
		F	276	342	245	281	232
Dementia Praecox	15-54	M	45	76	47	40	35
		F	38	53	51	34	33
Other Psychoses	15-64	M	56	118	53	51	39
		F	33	73	41	34	19
Alcoholic Psychoses	25-54	M	48	92	45	55	21
		F	11	27	9	8	9
Without Psychosis	15-64	M	63	109	83	53	51
		F	35	58	53	26	29
Manic-Depr. & Invol.	35-64	M	26	34	27	23	23
		F	48	41	49	45	53

\*Since the main interest here is in an analysis of rate differences between areas, only brief mention will be made of two other rate-differentiating characteristics which may be observed in Table 1. The admission rates for the diagnosis CASSP are much higher than for the other diagnostic groups. A second differentiating characteristic is that of sex. For the 52-tract study area as a whole, males have higher admission rates for all diagnoses except manic-depressive and involutional psychoses. The male excess is particularly noticeable for the diagnoses of other psychoses, alcoholic psychoses and without psychosis. For a summary of several surveys of mental hospital incidence rates by diagnosis, age, and sex, see Rose (Ref. 12).

\*All tract rates were age-adjusted, using as a standard the city-wide rate experience. The tract rates are reported in Appendix Table B. All rates are based on the unweighted mean of census tract rates except for "52 tracts," AP Female, and MDI Male. In these three instances, the rates are based directly on the populations living in the areas.

Table 2. Mental Hospital First Admission Rates of Social Areas Expressed in Ratio to the Rate of the Entire 52-Tract Area, by Diagnosis and Sex, Syracuse, N. Y., 1935 to 1944

Diagnosis	Sex	Rate ratios: area rate/52-tract rate				
		52 Tracts	Area 3	Area 2	Area 1	Area 0
CASSP	Male	1.00	1.45	1.47	.79	.74
	Female	1.00	1.23	.89	1.02	.84
Dementia	Male	1.00	1.69	1.04	.89	.78
Praecox	Female	1.00	1.39	1.34	.89	.87
Other	Male	1.00	2.10	.95	.91	.70
Psychoses	Female	1.00	2.21	1.24	1.03	.58
Alcoholic	Male	1.00	1.92	.94	1.15	.44
Psychoses	Female	1.00	2.45	.82	.73	.82
Without	Male	1.00	1.73	1.32	.84	.81
Psychosis	Female	1.00	1.66	1.51	.74	.83
Manic-Depr.	Male	1.00	1.31	1.04	.88	.88
& Invol.	Female	1.00	.85	1.02	.94	1.10

within the same social area, as may be observed in Appendix Table B. A rate difference between two areas that is of such a magnitude that it would be expected to happen by chance five or fewer times in 100 is regarded as statistically significant.\* In Table 3, the results of the application of the statistical tests are presented.

Table 3. Significance of Rate Differences between Social Areas for First Admissions to Mental Hospitals by Diagnosis and Sex, Syracuse, N. Y., 1935 to 1944

Diagnosis	Significance of Rate Differences Between Areas:					
	3-0	3-1	3-2	2-0	2-1	1-0
CASSP . . . .	*	M	—	M	M	—
DP . . . . .	*	*	M	—	—	—
OP . . . . .	*	*	M	*	—	F
AP . . . . .	*	*	*	M	—	M
WP . . . . .	*	*	—	M	M	—
MDI . . . . .	—	—	—	—	—	—

Differences significant at 5 per cent level for: Each sex \*; Males only M; Females only F; Neither sex —.

An inspection of the first row in Table 3 provides an illustration of the interpretations which may be made for each diagnostic

\*For the diagnostic groups, AP-females and MDI-males, the test applied was that of the difference between two proportions. For the remaining 10 more sizeable diagnostic-sex groups, the "t test" was used to evaluate the significance of the differences between area mean rates.

group. For CASSP first admissions, Area 3 has a rate significantly higher than Area 0 for both males and females. This is the only significant finding for the CASSP female group. Male CASSP admissions yield three other comparisons which involve significant differences, viz. between Areas 3 and 1, Areas 2 and 0, and Areas 2 and 1. The results for the other diagnoses may be determined by inspection of the remaining rows.

A total of 72 comparisons of rate differences between areas has been evaluated for statistical significance. As Table 3 shows, 32 of these 72 comparisons are found to involve rates which differ at the 5 per cent level of significance. Furthermore, in all 32 of these significant comparisons, the area which had the higher rate had the greater number of undesirable environmental conditions.

Also, it may be noted in Table 3 that there is a tendency for the significant differences to be concentrated in certain rows and columns. For example, various rows which represent different diagnostic groups may be compared. In the bottom row, representing the manic-depressive and involutional group, it may be seen that none of the 12 inter-area rate comparisons yielded differences large enough to be statistically significant. In contrast, both for the other psychoses and alcoholic psychoses groups, eight of the 12 rate differences are significantly different. The findings are intermediate for the without-psychosis category which has six significant differences, and for the CASSP and dementia praecox diagnoses, each with five significant differences.

The general consistency of the direction in which the mean rates vary by area is also worthy of attention. The rate patterning, which may be observed in Table 1 or Table 2, may be described as follows: The mean rate of Area 3 is higher than that of Area 2 for 10 of the 12 diagnostic-sex groups. Likewise, for 10 of the 12 groups, the mean rate of Area 2 exceeds that of Area 1. Finally, the mean rate of Area 1 is greater than that of Area 0 in nine of the 12 comparisons. This patterning accounts for the heavy concentration of significant rate differences which occurs in the first and second columns in Table 3. Of the 12 comparisons in each column, there are, respectively, 10 and nine significant differences. However, in each of the last two columns only two significant differences appear.

Thus, the rate differences show most consistency in being significantly different between Areas 3 and 0, and between Areas 3

and 1. The rate differences are least consistently significant between Areas 2 and 1, and Areas 1 and 0. In summary, there appears to be a general tendency for the mean diagnostic-sex specific admission rates of census tracts to be somewhat higher for those social areas with a larger number of the specified undesirable environmental conditions. A marked exception to this tendency is displayed by the manic-depressive and involutional female admission group, for which the mean rate is highest in Area 0 and lowest in Area 3.

Finally, the patterning of significant inter-area rate differences obtained by males and females may be compared. There is a total of 10 inter-area comparisons in which the rates are significantly different for one sex only. In nine of these 10 instances, the rates are significantly different for males only. Thus, there is a slight suggestion that the admission rate differences between these specific social areas are larger for males than for females.

#### DISCUSSION

The findings of this study tend to supplement those obtained from prior epidemiological investigations of hospitalization for mental disorder.<sup>3</sup> To some extent, there are consistencies among the general findings of the various studies previously conducted in Chicago and Providence,<sup>2</sup> St. Louis,<sup>13</sup> and Cleveland.<sup>14</sup> These previous studies have revealed generally higher rates of hospitalization for the psychoses from the central, and/or economically depressed, areas of the community. These findings have been most consistent for the following diagnoses: dementia praecox, alcoholic psychoses, and general paresis. In Chicago, the finding also was obtained for the "without psychosis" group. The admission rates of the old-age psychoses (CASSP) and manic-depressive psychoses have demonstrated a less consistent association with these environmental characteristics. In fact, the findings for the manic-depressive group have tended to contrast with those obtained for the other diagnoses. For example, the Chicago and St. Louis studies disclosed a positive relationship between manic-depressive admission rates and average rentals.

In a general way, the results of this study are consistent with the previous findings regarding the area distributions of hospitalized cases of dementia praecox, alcoholic psychoses, and other psychoses. That is, the low socio-economic, tenement-type dwelling

area contiguous to the central business district tends to have the highest admission rates for these psychoses. On the other extreme, the lowest admission rates tend to be found in the upper socio-economic area with relatively few multiple dwellings and few people living alone. In Syracuse, this finding also applies to the two diagnostic groups, CASSP and without psychosis. However, the social variables which were examined in this study clearly do not exhibit a similar association for the female group of manic-depressive and involutional admissions.

In addition, the findings of this study reveal that while high-rate tracts tend to be concentrated in one low socio-economic area (Area 3), another group of low socio-economic tracts (Area 1) has relatively low rates. These two low socio-economic-status areas differ markedly in concentrations of multiple family dwellings and single-person-dwelling units. Thus, it is important to recognize that socio-economic status scores, derived from measures of occupation, education and rent, reflect only one socio-environmental dimension along which census tracts may be ordered. Recent investigators of the ecological structure of American cities have singled out family living styles and ethnic composition as two other significant aspects of social areas.<sup>15, 16</sup> Studies of the area distribution of delinquency<sup>17</sup> and of suicide,<sup>18</sup> as well as this present study, suggest that some of these other social area characteristics may be more closely associated than low socio-economic status with areas having a high incidence of various social problems.

Occasionally, it has been assumed that findings such as those reported in this study have established the contribution made by social factors to the production and development of mental disorder. While these findings can be regarded as being consistent with such an interpretation, the results cannot be viewed as establishing or confirming the role of social variables as contributing factors in the etiology of mental disorder.<sup>19</sup> Other equally plausible explanations can be offered.

The concentration of high-rate tracts in a particular type of social area might be a function of area differences in: (1) group definitions of mental illness and recognition of symptoms; (2) use of facilities other than mental hospitals for the treatment of recognized cases of mental illness; and (3) attraction or exclusion of

individuals on the basis of types of behavior accompanying the prodromal stages of mental illness.

The fact that various occupational and social categories tend to define mental illness differently, has been documented in several attitude surveys.<sup>20</sup> Some suggestive evidence has been provided that areas of different socio-economic levels may exhibit differences in the proportion of recognized psychotics who are hospitalized.<sup>21</sup> Also the adequacy of family resources and access to other community facilities for care and treatment may influence hospital incidence rates.<sup>22</sup> In a study of first admissions who already had long histories of mental illness symptoms, it was discovered that economic changes were more frequently precipitants of hospitalization than were incidents of bizarre behavior.<sup>23</sup>

The extent to which area of residence may be a result rather than a cause of mental illness should not be overlooked. The effect of mental illness on earning power is likely to be as severe as that of most physical illnesses. If some degree of job incapacity precedes hospitalization, a downward adjustment of housing and living standards may occur. This effect is likely to be most direct when it is the principal wage earner who is incapacitated. If the household is dissolved during the early stages of illness, residential movement will follow in many instances to the rooming house or tenement areas of the city. Another factor which may influence the decision of a family to move is the members' perception of varying tolerances of "odd" behavior in different areas of the community. Furthermore, McCaffrey and Downing have suggested that mentally healthy families living in rapidly deteriorating areas of the city may undertake "outward migration" to areas which are residually more desirable.<sup>10</sup> Finally, a serious technical limitation to drawing conclusions is that only rarely can one generalize, from such studies based on area associations, to the social characteristics of individuals—which differentiate high and low risk groups.<sup>24, 25</sup>

On the basis of the limitations of such "ecological" correlations, it is tentatively concluded that further replications of such studies are not likely to provide answers to the objections that have already been raised or to suggest significant new areas of etiological research. The numerous propositions about the contributions made by constitutional predispositions, early socialization experiences, and adult stresses and conflicts in the development of mental dis-

orders are more likely to receive adequate testing through the direct application of more refined techniques within the community, clinic and laboratory.

### SUMMARY

This study investigated intracity area differentials in mental hospital admission rates for several diagnostic categories. Rate differences were examined in relation to three area characteristics: socio-economic status, multiple-dwelling-unit structures, and persons living alone. Findings for each specific diagnosis were reported. In addition, certain general findings were noted and compared with the results of previous epidemiological investigations of the spatial distribution of mental disorder. Certain alternative explanations of these findings were mentioned, along with some implications for future research.

### APPENDIX

Table A-1. Average Annual Rate of First Admissions (Per 100,000 Population) to Public and Private Mental Hospitals of New York State by Sex, Age and Diagnostic Group: Syracuse, N. Y., 1935-1944

Sex and Age	Diagnostic Group					
	CASSP	DP	OP	AP	MDI	WP
Both Sexes						
<15 .....	0	2	3	0	5	21
15-24 .....	0	48	22	1	9	62
25-34 .....	0	54	36	14	21	50
35-44 .....	2	39	65	37	27	59
45-54 .....	13	25	61	40	43	35
55-64 .....	69	9	52	26	46	32
65-74 .....	246	3	31	8	27	8
75+ .....	487	0	10	2	0	4
Total .....	34	28	35	17	21	40
Males						
<15 .....	0	2	3	0	1	28
15-24 .....	0	55	28	1	6	73
25-34 .....	0	69	37	24	13	63
35-44 .....	1	42	93	60	18	81
45-54 .....	13	19	79	67	26	49
55-64 .....	75	5	62	42	40	46
65-74 .....	269	0	34	15	22	13
75+ .....	531	0	15	5	0	10
Total .....	34	30	44	27	15	53

Table A-1. Average Annual Rate of First Admissions (Per 100,000 Population)  
to Public and Private Mental Hospitals of New York State by Sex, Age and  
Diagnostic Group: Syracuse, N. Y., 1935-1944 (Concluded)

Sex and Age	Diagnostic Group					
	CASSP	DP	OP	AP	MDI	WP
Females						
<15 .....	0	2	3	0	1	14
15-24 .....	1	41	17	1	11	52
25-34 .....	1	41	35	6	27	38
35-44 .....	2	37	39	14	36	38
45-54 .....	13	31	44	13	61	21
55-64 .....	64	12	42	11	52	18
65-74 .....	227	6	28	2	30	3
75+ .....	457	0	7	0	0	0
Total .....	34	26	27	6	27	28

Table A-2. Number of First Admissions to Public and Private Mental Hospitals in  
New York State by Sex, Age and Diagnostic Group: Syracuse, N. Y., 1935-1944

Sex and Age	Diagnostic Group					
	CASSP	DP	OP	AP	MDI	WP
Both Sexes						
<15 .....	0	9	12	0	2	87
15-24 .....	1	171	80	4	31	226
25-34 .....	1	178	117	47	68	164
35-44 .....	5	119	198	111	82	178
45-54 .....	37	71	177	116	124	102
55-64 .....	134	17	100	50	89	61
65-74 .....	288	4	36	9	31	9
75+ .....	236	0	5	1	0	2
Unknown ....	1	0	1	1	0	0
Total .....	703	569	726	339	427	829
Males						
<15 .....	0	5	6	0	1	59
15-24 .....	0	94	48	2	10	127
25-34 .....	0	107	57	37	21	99
35-44 .....	2	62	138	89	26	120
45-54 .....	19	27	115	98	38	72
55-64 .....	70	5	58	39	37	43
65-74 .....	144	0	18	8	12	7
75+ .....	105	0	3	1	0	2
Unknown ....	0	0	0	0	0	0
Total .....	340	300	443	274	145	529

Table A-2. Number of First Admissions to Public and Private Mental Hospitals in New York State by Sex, Age and Diagnostic Group: Syracuse, N. Y., 1935-1944 (Concluded)

Sex and Age	Diagnostic Group					
	CASSP	DP	OP	AP	MDI	WP
Females						
<15 .....	0	4	6	0	1	28
15-24 .....	1	77	32	2	21	99
25-34 .....	1	71	60	10	47	65
35-44 .....	3	57	60	22	56	58
45-54 .....	18	44	62	18	86	30
55-64 .....	64	12	42	11	52	18
65-74 .....	144	4	18	1	19	2
75+ .....	131	0	2	0	0	0
Unknown ....	1	0	1	1	0	0
Total .....	363	269	283	65	282	300

Table B. Average Annual Age-Adjusted Rates of First Admission (Per 100,000 Population) to Mental Hospitals in N. Y. State for Selected Sex, Age and Diagnostic Groups: Census Tracts and Social Areas of Syracuse, N. Y., 1935-1944

Social Area	Census Tract	CASSP			DP		
		Age 65+			Age 15-54		
		Both Sexes	Male	Female	Both Sexes	Male	Female
3	23	181	179	183	55	70	42
	31	353	466	235	82	90	74
	32	449	465	452	72	77	67
	33	488	493	485	75	88	62
	40	433	520	361	35	40	29
	41	515	721	339	67	92	42
2	13	204	200	213	77	52	101
	16	352	783	92	64	62	66
	34	517	587	465	32	34	30
	39	278	238	300	45	45	45
	42	511	639	398	55	57	54
	43	201	431	0	20	34	10
1	2	361	334	376	41	37	44
	5	105	106	106	31	47	13
	6	216	229	206	35	46	23
	7	211	273	149	22	0	44
	8	250	401	129	27	18	36
	14	286	359	221	26	30	22
	15	298	295	301	30	21	38
	20	214	259	173	38	40	36

Table B. Average Annual Age-Adjusted Rates of First Admissions (Per 100,000 Population) to Mental Hospitals in N. Y. State for Selected Sex, Age and Diagnostic Groups: Census Tracts and Social Areas of Syracuse, N. Y., 1935-1944 (Continued)

Social Area	Census Tract	CASSP			DP		
		Age 65+			Age 15-54		
		Both Sexes	Male	Female	Both Sexes	Male	Female
1	21	186	125	251	59	83	34
	22	230	398	86	58	94	20
	24	192	77	314	51	60	42
	25	234	305	164	17	25	8
	27	78	0	141	44	22	66
	28	524	402	640	20	20	20
	29	422	189	610	37	45	30
	30	461	453	479	56	66	47
	38	230	84	353	31	30	33
	52	348	343	352	47	35	58

Table B. Average Annual Age-Adjusted Rates of First Admissions (Per 100,000 Population) to Mental Hospitals in N. Y. State for Selected Sex, Age and Diagnostic Groups: Census Tracts and Social Areas of Syracuse, N. Y., 1935-1944 (Continued)

Social Area	Census Tract	OP		WP		AP	MDI
		Age 15-64		Age 15-64		Age 25-54	Age 35-64
		Male	Female	Male	Female	Male	Female
3	23	125	22	51	30	82	57
	31	139	69	152	50	114	62
	32	124	126	98	122	132	0
	33	109	95	100	44	102	41
	40	81	39	74	40	67	37
	41	128	88	182	62	56	49
2	13	71	48	56	9	51	0
	16	50	26	107	118	61	64
	34	32	52	86	39	50	63
	39	47	25	61	32	51	34
	42	67	62	140	86	58	77
	43	53	33	48	34	0	54
1	2	51	27	17	33	65	53
	5	35	37	44	11	58	25
	6	55	20	21	27	43	40
	7	27	0	39	26	86	28
	8	8	44	47	39	12	70
	14	49	35	40	13	46	87
	15	64	24	36	25	44	45
	20	47	21	31	6	33	30

Table B. Average Annual Age-Adjusted Rates of First Admissions (Per 100,000 Population) to Mental Hospitals in N. Y. State for Selected Sex, Age and Diagnostic Groups: Census Tracts and Social Areas of Syracuse, N. Y., 1935-1944 (Continued)

Social Area	Census Tract	OP		WP		AP	MDI
		Age 15-64		Age 15-64		Age 25-54	Age 35-64
		Male	Female	Male	Female	Male	Female
1	21	66	34	30	0	74	30
	22	34	61	83	44	124	18
	24	107	40	60	77	31	57
	25	72	26	63	29	61	56
	27	31	46	70	9	33	70
	28	44	8	52	17	44	16
	29	74	40	70	0	49	28
	30	87	87	97	47	107	76
	38	37	36	68	50	24	29
	52	25	26	81	23	65	48

Table B. Average Annual Age-Adjusted Rates of First Admission (Per 100,000 Population) to Mental Hospitals in N. Y. State for Selected Sex, Age and Diagnostic Groups: Census Tracts and Social Areas of Syracuse, N. Y., 1935-1944 (Continued)

Social Area	Census Tract	CASSP			DP		
		Age 65+			Age 15-54		
		Both Sexes	Male	Female	Both Sexes	Male	Female
0	3	180	0	344	17	37	0
	4	236	225	245	34	51	19
	9	277	472	135	9	0	16
	10	178	145	198	41	45	37
	17	442	518	381	41	68	20
	18	49	0	90	36	46	25
	19	166	0	271	26	27	25
	35	319	257	370	58	65	52
	36	0	0	0	12	0	23
	44	282	141	371	73	91	58
	45	245	263	230	33	15	47
	47	133	140	127	11	0	18
	49	143	0	237	37	38	36
	50	341	316	353	26	29	22
	51	340	519	189	44	56	33
	53	275	316	245	34	37	31
	54	338	333	342	25	24	27
	57	252	411	117	43	0	86
	58	354	561	213	41	46	35
	59	255	274	239	45	51	39
	60	167	119	211	25	12	36
	61	234	292	193	42	43	41

Table B. Average Annual Age-Adjusted Rates of First Admission (Per 100,000 Population) to Mental Hospitals in N. Y. State for Selected Sex, Age and Diagnostic Groups: Census Tracts and Social Areas of Syracuse, N. Y., 1935-1944 (Concluded)

Social Area	Census Tract	OP		WP		AP	MDI
		Age 15-64		Age 15-64		Age 25-54	Age 35-64
		Male	Female	Male	Female	Male	Female
0	3	44	0	46	0	22	56
	4	24	11	25	23	19	31
	9	56	7	87	7	13	82
	10	64	0	16	24	24	66
	17	68	22	88	17	0	91
	18	47	23	48	30	0	43
	19	64	15	22	15	0	13
	35	36	0	36	52	23	49
	36	42	20	33	20	15	56
	44	33	23	66	25	19	77
	45	29	15	55	66	28	43
	47	56	0	41	48	0	60
	49	16	29	33	0	0	26
	50	22	24	47	39	11	72
	51	31	55	40	23	36	25
	53	25	40	118	57	20	66
	54	31	21	42	23	82	15
	57	25	37	63	37	19	45
	58	47	7	48	62	0	54
	59	28	19	43	14	88	71
	60	33	21	66	33	17	62
	61	35	20	51	22	32	62

Table C-1. Selected Environmental Characteristics of Four Social Areas: Syracuse, N. Y., 1940

Mean of Census Tracts in Area			
Social Area	Socio-economic Index	Av. Dwellings per Structure	One-Person Households*
3	92.7	3.12	7.3
2	97.4	2.50	4.8
1	93.5	1.59	1.3
0	107.1	1.32	1.2
Total	99.6	1.75	2.4

\*Percentage of population in one-person households, omitting those living in rooming houses, hotels, institutions, etc. from numerator and denominator.

Table C-2. Selected Environmental Characteristics of Census Tracts in Each Social Area: Syracuse, N. Y., 1940

Social Area	Census Tract	Socio-economic Index	Av. Dwellings per Structure	One-Person Households*
3	23	92.0	2.92	4.8
	31	94.0	5.41	15.3
	32	90.2	3.01	9.0
	33	95.4	2.44	4.6
	40	93.1	2.59	6.2
	41	91.4	2.37	4.0
2	39	98.4	2.24	4.6
	13	85.8	2.25	1.3
	42	89.6	2.62	1.5
	16	107.6	2.94	11.4
	34	100.8	2.55	5.5
	43	102.1	2.37	4.4
1	2	95.2	1.43	1.7
	5	88.0	1.69	1.4
	6	94.7	1.44	1.0
	7	95.7	1.34	0.8
	8	97.3	1.35	1.0
	14	90.4	1.57	1.1
	15	94.7	1.55	1.7
	20	89.4	1.45	0.9
	21	88.2	1.93	0.8
	22	91.7	2.19	2.9
	24	91.2	1.85	1.9
	25	90.4	1.52	0.4
	27	98.8	1.36	1.5
	28	99.0	1.35	0.8
	29	93.9	1.51	1.1
	30	88.8	1.82	2.3
	38	96.9	1.52	1.0
	52	98.1	1.81	1.9
0	3	102.1	1.12	0.7
	4	102.0	1.17	0.8
	9	118.3	1.15	0.6
	10	100.6	1.39	1.1
	17	105.9	1.28	0.6
	18	104.4	1.34	1.3
	19	108.5	1.10	0.4
	35	105.0	1.64	1.2
	36	113.3	1.13	0.1
	44	113.9	1.54	3.8
	45	111.5	1.34	1.3
	47	122.6	1.04	0.1

\*Percentage of population in one-person households, omitting those living in rooming houses, hotels, institutions, etc. from numerator and denominator.

Table C-2. Selected Environmental Characteristics of Census Tracts in Each Social Area: Syracuse, N. Y., 1940 (Concluded)

Social Area	Census Tract	Socio-economic Index	Av. Dwellings per Structure	One-Person Households*
0	49	106.6	1.25	0.6
	50	115.1	1.25	1.1
	51	103.3	1.41	1.5
	53	100.9	1.92	3.2
	54	102.9	1.53	1.3
	57	104.7	1.25	0.7
	58	102.4	1.34	1.2
	59	101.9	1.46	1.8
	60	103.5	1.15	0.9
	61	106.1	1.15	1.2

\*Percentage of population in one-person households, omitting those living in rooming houses, hotels, institutions, etc. from numerator and denominator.

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## EDITORIAL COMMENT

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### JAMES N. PALMER, M.D.

James N. Palmer, M.D., associate editor of this journal since 1941, and a most valued friend, died suddenly at his desk in his New York City office on December 2, 1958. He had known his heart was undependable—for some time. He had just dismissed his last patient of the day; the Palmers were planning to entertain friends at dinner; he telephoned his wife to mix his cocktail; he was about to start the short walk from office to home. When he did not appear, a friend and colleague who was to have dined with the family walked to the office and found him dead.

THE QUARTERLY long ago was compelled to abandon the general practice of publishing memorials to colleagues, however eminent. It has, however, continued to honor departed members of its editorial board; it has seemed the last pitiful tribute we could offer to one of our own. Jim Palmer was very much one of our own. He was a colleague whose editorial ability, professional insight and clarity of judgment are already sorely missed. But he also had a capacity for friendship, we who remain were his friends; and these words are written with a sense of deep grief and bereavement.

When Jim Palmer first became associated with THE QUARTERLY, he was a young doctor on the staff of Utica State Hospital; he was only 47 when he died. He brought to THE QUARTERLY, not only a remarkably keen clinical sense, but an extraordinary capacity for editorial work and editorial judgment. Those in a position to know are convinced that, if he had not chosen to remain a medical man, he could have been a highly competent professional writer. However, he had chosen medicine naturally as a career. He was born in Glens Falls, N. Y. in 1911, the son of a surgeon; and, although he himself never practised surgery, he devoted himself to medicine. A graduate of New York University, which he attended on a full scholarship, he received his medical degree from McGill in 1937. After a general internship, he joined the staff of Utica State Hospital, then had a fellowship at the Austen Riggs Foundation. He returned to Utica, where he entered military service in 1942. As an army psychiatrist, he served as assistant chief and

chief of neuropsychiatric services in Australia, New Guinea and the Philippines. Shortly after leaving the army in 1946, he was married to the former Ann Scully, who survives him. He was again in Utica for about a year, then went to New York City for psychoanalytic training, which he completed at the New York Psychoanalytic Institute. During this period he was assistant chief of the mental hygiene clinic at the Bronx Veterans Administration Hospital, then entered private practice.

In Dr. Palmer's death, psychoanalysis and the larger profession of psychiatry have lost a man whose unusual talents were just beginning to be evident. This journal has lost an editorial adviser of broad knowledge and interests and of wide tolerance. His psychoanalytic training was on "orthodox" lines, but he could regard with appreciation contributions from sources which might include anthropology, extrasensory perception, highly unorthodox analysis, or Adlerian therapy. He was not devoid of bias; but he recognized it frankly. He usually disqualified himself from giving opinions on scientific papers involving military psychiatry or shock therapy; he did not "believe in" either, and he would remind one quietly of this by stating he could not give a fair judgment. On the many subjects where he felt his judgment could be fair, his competence and his insight were such as to be sorely missed by his editorial board colleagues.

Jim Palmer was a man without fanaticism, a verdict he would particularly appreciate, as the expression was one of his own highest tributes in criticizing scientific work. He was also a man who refused to look at himself too seriously or accept his own profession too grimly. He used to remark that it would be fun to be an anesthetist and spend all his spare time blowing a trumpet in a dance band. (As a matter of fact, there was a time when he was adept at both specialties!) Perhaps this ability to be less than fanatically earnest helped him with his patients. He brought modesty and diffidence to his clinical work, besides insight and sympathy.

It is difficult to write adequately of the personal qualities of a friend. One may, to the friend himself, half-jokingly use the familiar terms of psychoanalysis or psychiatry; but one still views his personality in older and homelier, if perhaps less accurate, words. So we think of Jim Palmer as a diffident, almost shy, man, in whom we, nevertheless, recognized a never-flaunted high intelli-

gence, an unflinching sense of proportion, and an astonishing and often irreverent sense of humor. We saw, too, a friend whose cultivation was not only in the expected, and often neglected, fields of general science, art and literature—but in such irrelevant things as addiction to dance music and ability to look over a stenographer's shoulder and correct her shorthand.

We remember, too, as part of the picture, such trivialities as his off-hand comment on the unmental variety of hygiene involved in large doses of fresh air, specifically fresh winter air at night in the chill climate of Utica. "Outdoor air," he said, "is all right in its place; its place is outdoors!" And it will be long before his colleagues on *THE QUARTERLY* forget his neatly typed notes: "I disagree with this author on all counts, but I recommend that his manuscript be published in *THE PSYCHIATRIC QUARTERLY*."

When Jim Palmer left Utica for further training, there was unusual gloom in his wards. A patient, whose own difficulties were disabling psychoneurotic symptoms, remarked sadly, "There goes the only man who ever understood the patients." Could there be a higher tribute to a psychiatrist?

## STICKS AND STONES—AND SOME NAMES TOO!

It was Lin Yutang who recently intimated that the Western World might wage a better cold war with the Communists if it adopted the ancient military principle that the best defense is an attack.\* A cold war is a war of words—of threats, misrepresentations and denunciations—and of provocative incidents just petty enough to avoid precipitating actual fighting. An injured tone of righteous self-defense when attacked thus, only leads the observer to conclude, Lin suggests, that there is something wrong to be defensive about. A better defense, he indicates, in his modern plea to carry the war into Africa, would be to attack by constant and vigorous official denunciation of the Red enslavement of Poland and Czechoslovakia, of the bald Chinese aggression in Korea, of the bloody Soviet murders in Hungary, and of the deadly slave camps in Russian territory itself. The west should keep the minds of observers on displays of Soviet tyranny, not on our own shocked protestations of injured innocence—with “neutralist” suspicions that it may not be all innocence.

One may leave Lin's specific, and possibly sound, suggestion for international action to the diplomats—and wonder if something like it might not be applied to a little cold war that has been waging for these many years in psychiatry, with the public mental hospitals defending themselves in the role of injured innocents.

To adopt Lin Yutang's advice for the moment, one might start by inquiring who, what and why are the people who have been sniping at the public mental hospital systems. Identifying them calls for a wide sweep, much generalization, and many unavoidable implications that this group or that individual who should not be included is in the enemy ranks. This, therefore, is an explicit invitation to anybody whom the shoe does not fit to refrain from trying it on. A further explicit statement also seems called for. It is that Brutus is—emphatically—an honorable man. Contrary to cold-war custom, this is not an attack on anybody's motives. The conscious rectitude of the snipers is only too obvious, though there are those who may think it regrettable that some of them do not have more insight into unconscious motivation.

To return to the attack, why not start with the private institution people who are prominent in criticizing state and federal mental

\*Lin, Yutang: *The Secret Name*, Cudahy, New York, 1958.

hospitals by allegations of public lack of leadership in treatment and research. These people cannot themselves do what they reproach the public mental hospital systems with not doing efficiently. Their research is limited to comparatively small numbers of highly selected patients—or is often nonexistent; their treatment is frequently curtailed by lack in the ordinary private institution of enough expensive equipment, of therapists trained and experienced in special treatment modalities, of psychologists thoroughly versed in personality evaluations, and of social workers experienced in dealing with patients' families.

The small private institution is hampered because it cannot afford these things. It often can't afford them in spite of charges which would frighten Croesus, Midas or the Aga Kahn. How would the private institution like to defend itself against a serious attack on its charges? Not that the charges are not necessary! Who would not prefer fine foods and soft music at Haven in the Himalayas to beef stew and clattering crockery at Cape Town (Alaska) State Hospital? But accommodations of the luxury hotel type must be charged for—at rates that can be met comfortably only by the very wealthy—and that even then do not provide enough above hotel prices to buy elaborate equipment or finance extensive research.

If the private-institution critics of the big hospital systems succeed in doing away with them, would they then bankrupt families of modest means by their charges, send less well-off patients to the jails and almshouses of a century ago, or undertake vast charity operations? If they chose charity, could they raise charges to a few very wealthy patients high enough to meet the charity need, or would they expect government grants—thus turning private hospitals into new government institutions to replace those they destroyed?

It may be time that somebody on the other side of the cold war stood up in meeting—as Solomon recently did in an attack on the public institutions\*—and told the private institutions what is the matter with them. The large public institutions are subject to legitimate and maybe severe criticism; so are the small private institutions—and more so. For the big public institutions are do-

\*Solomon, Harry C.: The American Psychiatric Association in relation to American psychiatry. Presidential address at 114th annual meeting, May 1958. *Am. J. Psychiat.*, 115:1, 1-9, July 1958.

ing a job, if imperfectly, that the private hospitals could not begin to cope with at all. Even Solomon recognizes this in suggesting that, when the big hospitals are abolished, many chronic patients should be removed from the hospital scene altogether by the establishment of undefined new "facilities" for "care and custody," and without treatment programs, although auxiliary hospital services would be provided somehow. This is either a shockingly callous proposal or a proposal for a distinction without a difference as far as "back-ward" patients are concerned, and it is difficult to believe that it was made seriously. It is certainly neither an acceptable nor a practicable way to get rid of the public mental hospitals.

Some of the critics should make a new start. There are splendid private institutions that need no defense. But there are others where—to understate—conditions are certainly not superior to those of the better public institutions. How do the people who operate these last institutions justify charges that would ruin many a middle-income family? What contribution do these critics think they are making to the general problem of medical, not to say psychiatric, service by attempting to destroy institutions they are not prepared to replace? It is evidence of intellectual bankruptcy, as well as moral irresponsibility, to attempt to destroy something essential without providing an adequate structure to serve in its stead.

Besides the intellectually bankrupt, who else are the cold war guerrillas? Some of them are people who very understandably prefer the better incomes and easier lives of private institutional work to the long hours and stiff competition of public employment—and then justify themselves by repeating the folklore to the effect that civil servants are incompetent and inefficient loafers. Some of this has its roots, as this journal has pointed out before,\* in a displacement of an unresolved Oedipal reaction toward authority. Most psychiatrists have had public institution training; the childhood rebellion against the authoritative figure is succeeded by the professional rebellion against the authoritative institution. To defend against these people by attacking them, one simply points out—in a superior fashion—that they are in need of psychotherapy.

\*Editorial: Paranoid Factitia. *PSYCHIAT. QUART.*, 31:3, 556-567, July 1957.

Then there is the fanatic fringe of hate-government people. Their attacks on the mental institutions are part of a reaction against government activities in general. One would not care to label "fanatic" everybody who wants to cut the United States government down to size; the fanatics merely share and follow their views. Basically, fanatic and non-fanatic also are reacting against what they regard as excessive use of authority by attacking the mental institutions. One may cite *Mental Robots*\* by a medical man who is a surgeon, not a psychiatrist, and who, one may assume, is not a fanatic. Dr. Alesen does not like the federal income tax, which he considers an instrument devised by the Marxists to destroy our form of government—a tax advocated in *The Communist Manifesto* by Marx and Engels. He does not care for the workings of such government-operated agencies as the post office, and he would like to get rid of some hundreds of government corporations, a number of "cartels" and some thousands of government bureaus, and "individual enterprises" which compete with private enterprise (he thinks the national defense expenditure "at the moment, seems reasonably justified"). In the process, he would put an end to all public mental hospitals. He suggests that there are "several ways" of doing it!

"...the public hospitals now in operation could be leased for long terms by the public officials in control to organizations such as are now operating our well-managed private hospitals, and the patients therein could receive care by these private hospital managements and the physicians on the staff under terms of the contract between the public authority and the private hospital. ...Of course, it [this project] would meet strenuous opposition on the part of those who hold vested interests in the continuation and expansion of present methods. Particularly loud and long would be the wails from the public health officials and those in charge of mental institutions as they saw imminent prospects of losing most fertile fields for expansion and exploitation of their pet ideas, but the poor downtrodden American taxpayer could be expected to respond with real gratitude. . .

"Again, it would be quite possible to finance expansion of the voluntary hospital plant through loans from private bankers not in any manner tainted by . . . federal and state control . . . [Dr. Alesen suggests that such expanded voluntary hospitals could then

\*Alesen, Lewis Albert: *Mental Robots*. Caxton Printers. Caldwell, Idaho. 1957.

make long-term contracts with local governmental units—he gives Los Angeles County for an example—for care of “the indigent,” the county government and its taxing power guaranteeing payments.]

“Also, . . . a [Blue Cross and Blue Shield] policy could be so written as to include a reasonable amount of psychiatric care, and the premium costs would not be prohibitive, when averaged over the millions of subscribers now participating in these voluntary plans.”

Dr. Alesen, enthusiastic surgeon, makes a deep cut. The great mental hospital systems are not the only detestable growth to be cut out of government. In the case of federal activities, one perhaps should be thankful that, however regretfully, the army, navy and air force would be left. With the income tax abolished, it would be necessary (and “most salutary,” Alesen thinks) for the amputee government to go “to the states for a portion of its income.”

How does one carry the war to this sort of critic? A good way would be to assist in the widest possible publicity for his views. The few excerpts cited are mild expressions compared to the general context from which they are lifted; and in these excerpts alone are a dozen affect-laden phrases in contempt of the public mental hospitals or in praise of private hospital management or its worth to the public. The intended victims could hardly wish for a more complete *reductio ad absurdum* of their enemies' views.

There is a common theme running through all the sniping; and it might be well to attack the attackers on the basis of it. They seem to believe vaguely that there is some virtue in smallness. The small private hospital is better than the large public hospital in a big hospital system. Or a psychiatric ward in even a public general hospital is better than a state hospital, designed, equipped and staffed for psychiatric purposes.

These advocates of ripping the existing treatment fabric into bits and scattering the bits here and there are of various political and economic persuasions. They are not all believers in private enterprise as contrasted to governmental, for some of them would be happy enough with government hospitals if the hospitals were small enough and/or non-psychiatric enough. There are no strict party lines; the enemy probably includes both extreme rightists and extreme leftists, the latter on the well-known Communist

grounds that the more one can damage any existing agency of any capitalistic government, the sooner the breakdown, and the better for the eventual society of Marxism.

More important than these suppositious few, of course, are those who believe that anything at all that is done by private enterprise is better than anything whatever that is done by government; any clerk, lawyer or doctor who works for himself or a corporation is superior to the degenerate clerks, lawyers and doctors who loaf on the government payroll. The doctor in private practice is keen, hard-working, enterprising, intelligent; the doctor in public employ is dull, time-serving, unenterprising—and, somehow, unintelligent, or he wouldn't be in public employ. Some of the extreme private-enterprisers sound as if they would be glad if we could return to the imperial Roman system of tax-farming; happy if we could turn the post office over to the express companies; overjoyed if the navy could be reorganized on the basis of privateers and letters of marque; and gratified if the army could be split up among the states, or maybe among the big cities. Police services could be supplied by the lowest bidders among the private detective agencies; and we might return to volunteer fire companies. Private school corporations could take over education, as has been proposed in some of the southern states; we wouldn't need so many schools anyway, for, if the government minded its own business, education would be a private affair, and not every parent would bother to send his children to school.

Most of the enemies of the mental hospital systems, however, do not go this whole way. A good many of them would be happy enough with public hospitals if the public hospitals were not state-controlled or federal-controlled, or were small enough. The principal characteristic the snipers share seems to be a dislike of size. Whatever its actual condition, the psychiatric division of Bellevue Hospital can be accepted as all very well, but re-name it Bellevue State Hospital and put it in a system with two dozen more institutions; and Bellevue becomes a horrible dump to which one would not exile a doctor convicted of a felony. There is evil in the paternalistic nation or state, good in the more or less impotent county.

Partisans of the small, and, if possible, feeble unit of government have raised their voices throughout history. Milan under the corrupt Visconti was to be preferred to a united Lombardy or

a united Italy; independent Vermont was more to be emulated and admired than the then-confederated United States of America. The smaller and weaker the government, the better; there might be social, economic or even military power within, but it must not be governmental. This has been the doctrine of feudalism throughout the ages: powerful barons, powerful merchants, strong guilds, strong cities—but weak central authority. Three thousand years of the history of Egypt alternate between intolerably strong central authority and intolerably chaotic feudalism.

Feudalism, whether economic, military or social, has a certain appeal to the ambitious and self-centered person of moderate ability. He can gain an enviable position from which he might be barred by a centralized authority. Or he can help control a local baron, or a local guild, or a local manufacturer easier than he can influence firmly-established and wider power. In today's industrial nations, most people believe that there are areas where local control by a little government is ideal, and other areas where the business of the world is done better through a larger agency. And in the interests of political and economic freedom, some of the larger jobs are best performed by a large governmental agency, where the individual citizen has some voice in its ultimate direction. Most people recognize that there are bad little organizations and good big ones, bad city governments and—at least occasionally—good state and national ones. The issue should turn on whether a job is being done well. For the feudalist, it doesn't; it turns on whether a job is being done by a little agency or a big government one.

It has been said that the motivations of the feudalists are many and their origins multiple. "Some of our best friends..." Well, consider the professor of psychiatry in medical school or post-graduate school who discourages his students from taking residencies in state hospitals or Veterans Administration hospitals. The university hospital or the medical center's neuropsychiatric institute is recommended instead. And the young doctor gets excellent, intensive, and much too narrow training there. No quarrel will be taken up here with such training; the young physician who can get it is fortunate. But he is not fortunate if he takes it to the exclusion of the broader training of the bigger institutions. A residency in a university hospital is most desirable, but such a residency should be complemented by (it might even be replaced

by) experience in a larger institution, handling a greater variety of patients.

The resident in a university hospital does not see enough patients or enough different patients. Those he does see are usually well screened and mostly of a type, psychoneurotics, mild schizophrenics, depressives—perhaps whatever is under current investigation. He sees them all too briefly from a single viewpoint, the one he has been taught—and is still being taught as his old professor supervises his residency. And he is being subtly directed, perhaps with the best motivation, perhaps wholly unconsciously, away from institutional practice where promising young doctors with an interest in, and aptitude for, psychiatry are badly needed. There are advantages—and very apparent ones—to training in a research institute or a university setting. But there are advantages to training in a large mental hospital that these smaller institutions can by no means provide.

The resident in a state hospital sees the wide variety of patients he will continue to meet daily in institutional practice, or whom he will encounter in private practice. He learns the differing characteristics and differing needs for care and therapy of such broad classifications as schizophrenics, seniles and depressives. He learns that there is more than one way to look at a patient—psychoanalytic, psychobiologic, eclectic, Adlerian—and that different viewpoints and consequently different theories and techniques of treatment are suited for different patients and for patients in differing circumstances. He gets clinical knowledge of most conditions, not book knowledge of most and clinical knowledge of a few.

The resident in a state hospital also learns from his colleagues and from the circumstances of residency. He meets the enthusiast, the fanatic, the discouraged, the cynic. He becomes acquainted with the realities of administration and budgeting. He comes into some contact, at least, with a tremendous variety of personal and family problems. Finally, he either decides he is suited for a career in institutional psychiatry and enters it with his eyes wide open; or he goes into private practice with a broad knowledge and understanding of mental illness and its problems. He may some day, of course, turn against the authority figure of the hospital which trained him.

But besides broad acquaintance with mental disorder in general, many state hospitals, including those of the New York State hos-

pital system, offer formal training courses to supplement residency experience. There are regular lectures and case conferences, many of them by outstanding authorities in their fields; there are postgraduate courses offered in collaboration with leading medical schools; there are assignments away from the hospital for special study. Many hospitals also have special research departments, in which the resident may observe, or take part in, very practical sorts of research. The young doctor forced to choose between the state hospital and the psychiatric department of a hospital teaching center would do well, in most instances today, to consider the state hospital carefully.

Furthermore, state hospital training may be the beginning of a highly satisfactory career, in clinical work, in administration, in teaching, or in research. Professor Feudalist, working to build up his own educational barony, is doing bad service to psychiatry and to science in general in discouraging young men from serving residencies in the institutions of the large mental hospital systems. One can fall deep into a dangerous rut in state or federal hospital practice—almost as easily as the private practitioner can do in giving short psychotherapy, electric shock or thorazine to everybody. But, in the public mental hospital systems, there are counterpressures, administrative, professional, and from public opinion, to force the clinician out of any easy, custodial-type routine.

Regardless of their origins (in which the great public hospital systems also have claim), the important "new" therapies of the last two decades: insulin, metrazol and electric shock; psychosurgery, group psychotherapy; the "tranquilizing" drugs; and now the new therapy of "open hospitals" owe their development in the United States to the large systems of state and federal institutions. The progress of research owes as much to the great mental hospital systems as does the progress of treatment. New York and Massachusetts have long had famous research institutions. California, Pennsylvania and New Jersey are other states now numbered among leaders in research; and there are research projects, departments and institutes in many other jurisdictions. Besides appropriations, federal grants and grants from private sources go to the support of state research projects—just as funds from one agency of government or another may finance private research projects. The significance of these observations, both in relation to treatment and research, is that the resident has a better oppor-

tunity in state service to become acquainted with the one, or to engage in the other, than he would find in the isolated public or private institution.

There is, of course, no better place in the world to learn medical administration and administrative principles and procedures (many of them useful for private practice) than in the state mental hospital. The physician progresses from a ward to a service, to a building, to a major hospital division, finally to administration of the hospital itself. There is profitable experience and good training here. There is not only the possibility of a self-gratifying and socially useful career; but if the resident leaves public service some day, he will have had a wealth of contacts with disciplines and ancillaries, and with a wide variety of personalities that he could never encounter on the psychiatric ward of a university hospital or in the psychiatric division of a medical center.

The young doctor who hopes some day to teach psychiatry will find the state hospital an excellent place to begin. He will doubtless start by lecturing to new attendants and to school of nursing classes. He will take visiting medical and psychology students on tours of the hospital, pointing out and demonstrating. He will present patients at staff meetings. As he learns more himself, he will counsel, advise and teach younger residents. Eventually, he may teach at a medical school where he may advance on the faculty until he devotes the major part of his time to teaching—if teaching suits him and he is suited to it. If and when he does teach, he will bring to his classes a wealth of clinical and other practical knowledge he could never have obtained if he had spent all of his formative years in a university hospital. And one hopes that he will recognize the value of his experience and recommend similar experience to his students.

The feudalists, the proponents of the little hospital, the psychiatric ward, or the isolated service, are attacking training and teaching institutions that they have no means to replace. There are many things to be said for decentralization, for local organization and control—especially in the fields of mental hygiene and orthopsychiatry. After considerable study of the need, New York State has inaugurated what, it may be hoped, will long be a model for community mental health programs.\* Its basis is the local

\*Forstenzer, Hyman K., and Hunt, Robert C.: The New York State Community Mental Health Services Act: Its origins and first four years of development. *PSYCHIAT. QUART. SUPPL.*, 32:1, 41-67, 1958.

operation, with state aid, of mental health clinics and other facilities short of hospitals themselves. These are community-managed, but professional standards and conditions of operation are set by the state. The state requires—not by law, but through the discretion of the commissioner of mental hygiene—that the medical directors of community mental health services have high professional qualifications. The state also requires, as a prerequisite for state aid, that services and administration meet high standards.

This New York program is a fine example of community effort, and, in general, of community success in meeting a mental health program. It is not, however, feudalistic. In 1259, Baron Hardecastle of Hempstead could—if he were fool enough—arm all his retainers solely with battle-axes, because he didn't like the sword or the longbow. In 1959, Dr. Hardecastle of (another) Hempstead cannot—even he is fool enough—treat all his patients with electric shock because he doesn't like thorazine or psychotherapy. The community will lose state aid if its mental health director does not know how to use suitable means (various means) for various ends. This brings one back around the circle to the question of training. Community mental health directors must be specially-trained psychiatrists; but the community health structures are not training-organizations. Training is considered a state responsibility; and the state is now granting stipends for advanced training for community-center psychiatrists, psychologists, psychiatric social workers and other specialists. And these people must obtain basic training in their specialities beforehand. The local mental health services are one type of local service that is equipped to do little, if any, training; they supplement but cannot displace the state hospitals.

So much for the moment, for the public hospital systems from the viewpoints of staff and prospective staff! Incredible as it may seem to the feudalists, they also have certain advantages for their patients. One was the subject of discourse in these pages recently.\* In noting that it was a long trip from Baden Baden to Stockton,\*\* it was remarked that famous spa at the start and state hospital at the finish had one therapeutic element in common. It is *Luftveränderung*, a change of air, which is understood to mean, not

\*Editorial: *Luftveränderung*. q. 1. ad. . . *PSYCHIAT. QUART. SUPPL.*, 32:1, 143-155, 1958.

\*\*California State Hospital.

only fresh air but a fresh environment as well. Healthful, regulated activity is also included. The health resort and most of the large public mental hospitals provide *Luftveränderung*. So do many of the high-priced private mental institutions. The psychiatric divisions and psychiatric wards of general hospitals—as a rule—do not have even the floor space!

To find anything in common between Aix-les-Bains and Gowanda (N. Y.) State Hospital may seem fantastic to the layman; he is likely to feel that—as Procrustes used to demonstrate—things can be stretched too far. But the matter is a commonplace to the psychiatrist—so commonplace that he seldom even thinks about it. The contrast is vivid enough: on the one side, luxurious room, mountain view, *chateaubriand* and a good Médoc, with soft lights and sweet music; on the other, a bed on a ward, a moderately pleasant view, meat loaf and indifferent coffee, with unshaded light, loud talk and loud clattering. But the elements they share make both spa and hospital of therapeutic efficacy—and for the same reason. Both alleviate the mild emotional disturbance sometimes known as a situation neurosis—by changing the situation. The hospital, in addition, may considerably relieve the symptoms of psychosis—also by changing the situation. The hospital as therapy is a well-known concept; every staff psychiatrist knows patients who appear superficially normal as long as they are in the hospital but are disturbed the moment they are released.

In the long, cold war with the feudalists, it is time for the large mental hospital systems to stress what they can offer and substitute-institutions cannot. The matter has already been touched upon, particularly from the point of view of the young doctor undergoing specialist training. A generation or more ago, the generally-accepted theory of mental hospital construction called for building institutions in the country where few neighbors could hear disturbed patients and comparatively few citizens would be compelled to look at the shameful structures. Suburban locations, or at least sites within commuting distance of medical centers and training centers, have been preferred for some years; and highway communications have improved to the point where even comparatively remote hospitals are within reach of teaching and training institutions. This assures the change of air and scene for the patient, where the psychiatric division or ward does not; and it brings the patient, as well as the doctor, within ready reach

of the most modern facilities for coping with acute somatic illness or operative emergency.

The matter of costs has been mentioned, but it should be re-emphasized. Compared with physical illness, even an acute and recoverable mental derangement is likely to be a protracted affair. Months of hospitalization in the mental case contrast with days or weeks in the physical. Even with today's hospital and medical care insurance plans, a family in moderate circumstances can be ruined financially by a long illness; and long illness is the rule in mental cases. A first-class private institution's bill for a year's treatment now runs considerably more than the modal American salary for a year. (The statistics will not be gone into here; but the figures are easily obtainable.) Those who can no longer afford long private hospitalization for mental illness now range from unskilled labor well into the ranks of the "upper middle class."

Today's situation is the result of too many factors for anything less than an electronic brain to cope with; among them are shifting social and economic circumstances, complicated by the scientific advance of medicine. Deranged old Uncle Joe once could be left to putter harmlessly around the farm, talking to his hallucinations for the few years before a pneumonia of old age took him hence. But he can't be left to putter around a city apartment house or a city street; and increasingly-costly medicine has stretched his few years of doddering existence into a decade or more of dotage. Even the comparatively well-off family cannot meet such a situation; and, so far, the state has proved to be the best agency to deal with it. This does not mean that old Uncle Joe or his family has become either indigent or an object of charity. He or his family will meet reasonable (and scaled to circumstances) charges for his care.

The difference between today's situation and that of other days is that what was once a family or individual responsibility is now a shared responsibility of family and community. If there is any way to avoid this sharing, the critics of the big mental hospital systems haven't pointed to it. Even Alesen concedes community responsibility—suggesting, however, that the community's charges for the "indigent" should be met by the counties, which would pay for farming out patients to private institutions. The county, however, does not provide a broad enough base for such allocations, a matter that even a superficial inquiry in the industrial parts of

the country will readily demonstrate. New York State's Community Mental Health Services Act, under which the state reimburses its counties for half their expenses for psychiatric services, is further evidence. The actualities in regard to individual and family were further recognized when the New York Legislature in 1957 amended the Mental Hygiene Law to strike out the words "poor" and "indigent" and similar expressions. This wrote into law recognition of a situation that had long existed in fact; the New York state hospitals are now legally maintained, not for the poor and indigent, but for the people of the state, with charges for hospitalization made according to ability to pay.

But some of the feudalists' quarrel with the institutions appears based on the idea that only an inferior breed of homo sapiens will enter public employment. One's own profession should be as open to criticism as any other; but it is not considered in the best professional circles to be acceptable manners for colleagues to hurl excrement at each other. Certainly, some deplorable specimens find their way to public hospital staffs; and when the private institutions rid themselves of nepotism, favoritism, inefficiency, incompetence, laziness and greed, they might be invited to help clean up the staffs of the public hospitals. There are some abuses which the set-up of the private institution invites and which cannot be found in public hospitals. It is next to impossible for the director of a public hospital to hire a benefactor's drunken brother or a politician's incompetent uncle as a member of his medical staff; there are mechanisms to prevent this sort of thing; some of them are known as competitive civil service examinations for appointment and promotion; and, while they do not eliminate all the bad boys, they get most of the worst sooner or later. There are no such safeguards of competence, of good behavior, and of interest in professional progress in the laws governing private institution professional staffs. They include many admirable and some distinguished figures; but they also include people who are incompetent, disreputable, or just plain jerks. It might be suggested that—as long as this condition obtains—it would be good manners for private practitioners who feel critical of public institutions to hang up the manure forks and criticize temperately.

Every once in a while, pent-up aggression (or a fair facsimile thereof) proves too much for some eminent figure in psychiatry, and he explodes with a denunciation of the tax-supported mental

institutions. There is nothing new, for example, about Solomon's outburst of last spring.\* His idea of custodial institutions for chronic mental patients was suggested 10 years before by a teacher and practitioner of psychiatry, Brian Bird,\*\* and nearly another decade before that by the widely-known and respected clinical psychologist, Harriet Babcock.† Custody, not treatment, had been, of course, the traditional nonmedical answer to the problem of mental disorder for centuries in the past. Society put its house in order by sweeping the dirt under the rug, hiding what it could not remedy.

Solomon's proposal is a little better in this respect than some of the previous ones, in that he does suggest "a hospital section," staffed by visiting specialists who would include psychiatrists, for each custodial establishment. Thus the patient condemned as chronic would not be absolutely and finally abandoned. Like the prisoner in the death house who has appealed for clemency to the governor, such a patient could always hope that he had a chance—in his case that a visit from the visiting psychiatrist would produce an executive miracle.

This smoothly-presented proposition should be fought with the utmost resolution on the same grounds that form one of the strongest reasons for opposition to euthanasia. Once the physician assents to euthanasia, he is agreeing to regard as forever hopeless medical conditions for which remedies may be found in the future. Once the psychiatrist assents to custodial care for chronic patients, he is in his turn abandoning men and women for whom hope may be found in the future. If Solomon's psychiatric limbos had been set up a dozen years ago, hundreds of now free men and women would be forgotten in them today. Since, however, these people had not been turned over to custodians but were on back wards where they were neither out of sight nor out of mind of the psychiatrists, they received the benefits of treatment with "tranquilizers" when the new drugs came along. Had Solomon's proposals been in effect, the psychiatrists—if these "hopeless cases" had been remembered at all—would still be arguing with the custodians about "uselessly" disturbing and agitating people who

\*Solomon, Harry C.: *Loc. cit.*

\*\*Editorial: Prison or Hospital. *PSYCHIAT. QUART. SUPPL.*, 22:2, 348-353, 1948.

†Time and the Mind. By Harriet Babcock, Ph.D. Sci-Art. Cambridge, Mass. 1941.

were adjusting nicely to being cared for under guard in something of a prison atmosphere.

It is grossly unfair, of course, to single out Solomon for criticism on the custodial issue, since others raised it before him; and the critic is always tempted to argue *ad hominem* and make unflattering comparisons between today's Solomon and the surpassingly wise Solomon of antiquity—the name alone is a sufficiently heavy burden to bear. When today's Solomon speaks as head of the American Psychiatric Association, however, and is of some personal repute for wisdom himself, the critic simmers and boils and finally finds the temptation too great to overcome.

But, in the interests of restraint, Solomon's outburst should be seen against the broad perspective of both near and distant attacks. For foreground coloring, one may cite remarks at the November 1958 Mental Health Assembly by Harvey J. Tomkins, chairman of New York City's Community Mental Health Board and vice president of the National Association for Mental Health. Dr. Tomkins urged that mental health associations do what they can to further the trend toward community treatment of mental disease instead of treatment in the "old, traditional mental hospitals, removed from the communities..."\* "Distant and isolated mental hospitals" is another loaded expression, not attributed to Dr. Tomkins himself, but given in a descriptive report of his speech. "Outmoded and custodial mental hospitals," "second-rate treatment" and "mere bed and board custody without treatment" are some other compliments by Albert Q. Maisel applied recently to the larger state hospitals and the care given in them. Mr. Maisel has crusaded for some years, valiantly but indiscriminantly, for betterment of the lot of mental patients.\*\*

Prominent in the background of this portrait of a critic, is the figure of C. Charles Burlingame, then psychiatrist-in-chief of the Institute of Living in Hartford, Conn., who came out in 1946 with one of the most sweeping denunciations of the state hospital systems to appear anywhere in the records.† It was a time of general assault on the public mental institutions, and THE PSYCHIATRIC

\*NAMH Reporter, 8:1, January 1959.

\*\*Maisel, Albert Q.: Let's get our mentally ill out of the hospitals. Better Homes & Gardens, 35:156, November 1957.

†One Hundred and Twenty-second Annual Report, The Institute of Living, Hartford, 1946.

QUARTERLY took note of it editorially.\* Besides Burlingame, the *Journal of the American Medical Association* came out with nasty remarks on the "political care" of the mentally ill in our hospitals,\*\* basing its attack on unjustifiable distortions and misrepresentations of the content of the report of the Moreland Act Commission, which investigated the New York state hospitals in 1943 and 1944. The editorial was a by-product of the *Journal's* famous phobia, "political medicine," at a time when American physicians were justifiably worried as to whether the United States would follow the lead of Great Britain and "nationalize" the country's medical profession. As such, it was understandable, though not excusable.

It might be interesting to know just how far blind distrust of all public enterprise and blind faith in all private enterprise (recall Alesen's "well-managed private hospitals") inspired two other critics of the period, the professional writers Albert Q. Maisel and Albert Deutsch.† Mr. Maisel, then as more recently, attacked without overmuch discrimination, presenting, for one thing, a patient's allegations of a murder as if it were an established fact. Mr. Deutsch presented the case against the mental hospital systems of a number of "backward" states in a fashion to imply that all states were backward—an implication Karl Menninger felt impelled to counter in his introduction by specifying Massachusetts, Connecticut, New York, New Jersey and Delaware as states where patients had good care and treatment.

This does not, unfortunately, begin to survey the field. The novelists, as volunteer public relations specialists, have continued to contribute to the bad reputations of mental hospitals from Ellen Philtine's satiric caricature, *They Walk in Darkness*, to André Soubiran's *Bedlam*, a highly sensational story of an antiquated French hospital for the criminally insane.‡ There have been partial correctives, but only partial, and no thanks to the novelist-critics for them! Some of them have been supplied by the patients

\*Editorial: The Root of Our Evils. *PSYCHIAT. QUART.*, 20:2, 332-344, April 1946.

\*\**J. A. M. A.*, September 2, 1944, p. 33.

†Maisel, Albert Q.: *Bedlam* 1946. Most of U. S. mental hospitals are a shame and a disgrace. *Life*, May 6, 1946, p. 102.

Deutsch, Albert: *The Shame of the States*, Harcourt Brace, New York, 1948.

‡Philtine, Ellen, C.: *They Walk in Darkness*, Liveright, New York, 1945.

Soubiran, André: *Bedlam*, Putnam, New York, 1957.

themselves, for example, Mary Jane Ward and Paul Hackett.\* Their books were testimony from personal experience, in a New York state hospital and in a hospital of the Veterans Administration, to the high quality of the care and the adequacy of the treatment offered in those institutions.

The good mental hospital systems already have, and the others can have, humane, scientific and progressive programs. The prejudiced people, peculiar people and paranoid people who make up the feudalism army of opposition have no programs, have manifestly unworkable programs, or have—as might be expected—medieval programs.

\*Ward, Mary Jane: *The Snake Pit*. Random House. New York. 1946.

Hackett, Paul: *The Cardboard Giants*. Putnam. New York. 1952.

## BOOK REVIEWS

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**Collected Papers.** By SIGMUND FREUD. First American edition. Five volumes. Vol. I, 359 pages; Vol. II, 404 pages; Vol. III, 607 pages; Vol. IV, 508 pages, with chronological list of contents of Vols. I to IV, and index of Vols. I to IV; Vol. V, 396 pages with index to Vol. V. Cloth. Basic Books. New York. 1959. Price \$25.00.

The most famous and the most quoted works of Sigmund Freud are in the *Collected Papers*. Clinical notes from a lifetime of practice, theoretical conclusions, essays on aspects of behavior and culture, interpretive comment on life, literature and art, the content of these papers has provided authoritative and comparative material for two generations of psychoanalysts. This reviewer has never seen a statistic on the subject, but he has the strong impression that there are more citations to the *Collected Papers* in the professional literature than to all Freud's longer books combined.

A readily available American edition of the *Papers* has been overdue for many years. The original collection was completed with the publication of volume IV in England in 1925. Volume V, which includes a few previously-omitted early writings, but consists largely of papers written between 1925 and the author's death, was published (at 25 shillings) in 1950. While the present publisher's note, that the *Collected Papers* have been "virtually unobtainable in this country," may be a slight, if entirely pardonable, exaggeration, they were certainly not to be found at any corner bookstore; acquiring a set was a time-consuming and expensive proposition. An American printing was badly needed, and its publication is an important event in the history of psychiatry.

Freud's shorter papers not only present a splendid collection of clinical and theoretical material; as they are arranged, they also illustrate the beginnings and the development of the psychoanalytic movement, with the constant increase in Freud's experience and the steady maturing of his ideas. Both Volumes I and V, for example, start with material from the period of Freud's interest in hypnosis: Volume I with a tribute written in 1893 in memoriam for Charcot, and Volume V with an essay which served in 1888 as Freud's introduction to the German translation of Bernheim's work on hypnosis, *De la Suggestion et de Ses Applications à la Thérapeutique*. And, at the other end of the chronicle, Volume V contains the famous paper written near the close of the author's long life on "Analysis Terminable and Interminable."

The new edition of Freud's papers, the reviewer is very glad to say, follows the London edition, page by page and word for word. It can

thus be used for citation or reference indifferently with the British original, which is a tremendous advantage for both writer and reader.

Volume I is made up of the "early papers," concluding with "The History of the Psycho-Analytic Movement," written in 1914. Volume II is largely clinical, although the editorial preface remarks that it is "'Clinical' only *a potiori*." It includes "The Sexual Enlightenment of Children" and "'A Child is Being Beaten.'" Volume III includes "Analysis of a Phobia in a Five-Year-Old Boy," the case of "little Hans"; and "Psycho-Analytic Notes upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)," the Schreber case. Volume IV is divided between papers on "metapsychology," treating of such subjects as narcissism and repression and including the much-quoted paper on "Mourning and Melancholia;" and papers on nonmedical applications of psychoanalysis, among these, "The Relation of the Poet to Day-Dreaming," "The Taboo of Virginity," "The Theme of the Three Caskets," and "The Moses of Michelangelo." Much of Volume V, of course, also falls in this classification, notably the discussion of "Dostoevsky and Parricide," and that two-page gem, "Medusa's Head."

The American edition now places this wealth of material in reach of every psychiatric and medical library. The edition is handsome, well-printed on good paper, bound durably in ecru linen; it compares more than favorably with the long-standard British edition. No psychiatric library can afford to do without it; and few psychiatric practitioners will care to.

**Psychopharmacology Frontiers.** NATHAN S. KLINE, M.D., editor. 533 pages including appendix. Cloth. Little, Brown. Boston. 1959. Price \$10.00.

*Psychopharmacology Frontiers* is the beautifully-printed record of the psychopharmacological symposium of the Second International Congress of Psychiatry at Zurich in September 1957. There were some 90 participants in the symposium, with about 60 major papers presented, and with discussions in five languages. The record, edited by Nathan S. Kline, M.D., is of particular interest to New Yorkers, since no less than a dozen members of the New York State Department of Mental Hygiene, including Dr. Kline, Assistant Commissioner Henry Brill, M.D., and former Commissioner Newton Bigelow, M.D., took part in the presentations and discussions. The symposium covered four major topics: an outline of general problems, clinical observations and descriptions, specific problems, and mode of action. Discussions followed presentation of the papers, and the discussants were drawn from the principal countries of Europe this side of the Iron Curtain, as well as from Canada and the United States. Contributors included Drs. Kline, Bigelow and Brill, R. A. Cleghorn, H.

C. B. Denber, L. H. Margolis, V. J. Kinross-Wright, G. J. Sarwer-Foner, Anthony Sainz, and numerous other investigators representative of psychiatry on both sides of the Atlantic.

The papers presented in this volume, most of them short, have been very smoothly edited and the foreign language contributions have been ably translated. The editor explains that many translations had to be published without final approval of the original contributors and that amendments were made which authors may not have seen. Without this procedure, it is difficult to see how this volume could have been published. It leaves, as the editor notes, a chance of misstatements, for which he apologizes.

It is this reviewer's opinion that early publication of a book of this sort is well worth the chances taken. The material is of urgent interest to present-day psychiatry, and the subject is one in which prompt publication is of vast importance. The symposium covers not only a wide field, but a wide variety of experience, opinion and theoretical background. The reader of this book will find the clinical section of particular interest and practical application; and under "Specific Problems," are half a dozen papers pointing to pressing and yet unsolved problems of psychopharmacology.

The volume should be of great use both as a handbook for the clinician and as an important source of recent general information.

**The Shook-Up Generation.** By HARRISON E. SALISBURY. 244 pages with index. Cloth. Harper. New York. 1958. Price \$3.95.

In this fascinating and angry book, Salisbury presents some interesting facts about gang boys that he has gathered while studying juvenile delinquency as a reporter for the *New York Times*. He discusses their language, style of life and need for security and status in a world that is neglectful and makes little effort to integrate them and their families into its life.

The "shook-up" youngster believes there is no cure for delinquency. It is not easy for the gang boy to leave the gang life; he has the constant, pervasive feeling that there will always be gangs and that boys will always be fighting. He believes it cannot be stopped.

Salisbury offers suggestions for solving a national problem that exists, not only in the cities, but also in the rural areas. His plan includes active interest in, guidance and care for, both individuals and large groups, and includes the integration of migrating populations into the established community. The proposals are on a grand scale; but the need is great. The author's plea for action is urgent. His book should be read, not only

by social workers, teachers and community directors, but also by parents and any other persons who feel concern for the community and the younger generation.

**Insulin Treatment in Psychiatry.** MAX RINKEL, M.D., and HAROLD HIMWICH, M.D., editors. 386 pages with index and appendix. Cloth. Philosophical Library. New York. 1959. Price \$5.00.

*Insulin Treatment in Psychiatry* is the Proceedings of the International Conference on the Insulin Treatment in Psychiatry, held at the New York Academy of Medicine, October 24 to 25, 1958. It is dedicated "In Memory of Manfred Sakel's Contribution to Psychiatry." More than 20 recognized authorities in the field were panel members, and 17, in addition to the editors, are contributors to the resulting volume.

The volume opens with a review by Hans Hoff of Vienna of the history of physical treatments in psychiatry, and, following a chapter by Samuel Bogach of Boston on "Neuraminic Acid in the Cerebrospinal Fluid of Schizophrenic Patients," is closed with a very useful review by Rinkel. Contributors and panel members include Paul H. Hoch, William Sargant, Joseph Wortis, Karl M. Bowman, Earl D. Bond, D. Ewen Cameron, Herman C. B. Denber, Jack R. Ewalt, Harry Freeman, Alexander Gralnick, Lothar B. Kalinowsky, Nathan S. Kline, Gerald J. Sarwer-Foner, Harold G. Wolff, and Joseph Wortis.

The book covers history, research and follow-up, including incidental and illuminating discussion of rationale under the two latter divisions. The appendix is made up of the facsimile of a citation given to Sakel in 1957 on the thirtieth anniversary of his discovery of the treatment of mental disorders by insulin, and of Sakel's address in reply. Sakel, characteristically, said he did not believe discoverers should be honored, since, "They do what they do because they are compelled to, either by some higher plan or by the endowment of their genes..." Homage, he said, should be paid instead to persons who supported discoveries by the whole weight of position and authority and at the risk a discovery would be a fiasco, citing Otto Poetzel and Hans Hoff. In his contribution to the present book, Hoff himself makes the capitalized statement, "Insulin treatment is the only successful biological treatment of our time."

The views of the contributors and panel members range from this unreserved endorsement to considerable conservatism on the subject, but with the consensus evident that insulin is not outmoded but is an essential tool of modern psychiatry. "I personally have always insisted," says Hoch, "that insulin treatment should continue and should be given. Today perhaps the only difference in the application of insulin treatment [from general practice in the past] is that we do not apply it as a primary treatment, but apply it in most instances with patients who failed with treat-

ments which are easier to administer, less expensive, less dangerous, and less cumbersome."

Whether personally concerned with active treatment or not, and whether engaged in clinical work, administration or research, any psychiatrist can make good use of this book.

**Passionella and other stories.** By JULES FEIFFER. Unpaged. Paper. McGraw-Hill. New York. 1959. Price \$1.75.

*Passionella* is a wonderful, beat-generation, Hollywoodized, version of Cinderella by courtesy of "a friendly neighborhood godmother" who comes via video. Besides this neat satire, the volume contains a little story about "Munro" whose adventures recall Frank Tashlin's delightful *Bear That Wasn't*. There is also a tale about "George" who owned and lived on the moon. And there is a concluding tale of horror called "Boom!"

This reviewer has never seen a better satire of the breast cult than *Passionella*. The other tales are sharp caricatures of human folly. Feiffer tells his stories in a combination of cartoons and hand-lettered legends, in a fashion to delight any pessimistically-oriented psychiatrist. The collection is enthusiastically recommended.

**The Harmless People.** By ELIZABETH MARSHALL THOMAS. 266 pages. Cloth. Knopf. New York. 1959. Price \$4.75.

Elizabeth Marshall Thomas was a lay member of a scientific expedition which journeyed to the Kalahari Desert to study and make films of one of the most primitive and mysterious people still left on earth. She describes a way of living, thinking and feeling that should interest everybody in social science from the economist to the psychologist. The African bushmen, who are not Negroes, are the remnants of a hunting-and-gathering people who have long been mistreated and oppressed by white men and black men alike. Because this is an exceptionally well-told story, it can be recommended for reading by the student who needs to learn that there are many ways in which to lead the "good life."

**You're Out of Your Mind, Charlie Brown!** By CHARLES M. SCHULZ. Unpaged. Rinehart. New York. 1959. Price \$1.00.

Charlie Brown has been out of his mind for a long time—in the same sense that most of the rest of us are. That is, he behaves as illogically and unreasonably as the average grown-up.

The present little book contains some of his more picturesque aberrations. As in the case of grown-ups, a lady is the inspiration for much of the best foolishness. The back cover is a drawing of Lucy, seated behind a lemonade-stand box with the label "PSYCHIATRIC CARE 5c."

**Loathsome Women.** By LEOPOLD STEIN, M.D., with MARTHA ALEXANDER. 243 pages. Cloth. McGraw-Hill. New York. 1959. Price \$4.50.

*Loathsome Women* is the account of the treatment, by the "analytic psychology" method of C. G. Jung, of four patients with emotional and neurotic symptoms. The author is a British psychiatrist who is assistant editor of *The Journal of Analytical Psychology* and who has been chairman of the Society of Analytical Psychology.

The present book is not technical but is intended for general reading. The practitioner, nevertheless, will find in it much of interest in both theory and technique. The reviewer gathers that in this form of psychotherapy value judgments and moral judgments play a part, as implied in the book's title, even though they may not be expressed to the patient by the therapist. The technique is also far more active than the conventional psychoanalytic method of free association and interpretation.

However, this book unfortunately is represented on the dust jacket as psychoanalysis. Dr. Stein refers to himself in the introduction as an analyst; as he is an analytical psychologist, this is a term to which nobody could possibly take exception, but which is misleading—particularly to lay readers in the United States—in the context. The reviewer thinks that a great many psychotherapists will find this book of interest and possibly of some profit. He thinks it is not unadapted for general reading by a well-informed lay person if the reader understands that it does not represent psychoanalysis, either of the orthodox Freudian or neo-Freudian type. Its general circulation without making this plain seems to the reviewer to be most unfortunate and likely to give rise to serious misapprehensions and misunderstandings.

**The Inland Whale.** By THEODORA KROEBER. 205 pages. Cloth. Indiana University Press. Bloomington. 1959. Price \$4.50.

Mrs. Kroeber's book of stories is authenticated by her own experience as a psychologist and her acquaintance with her anthropologist-husband's work in the area from which the tales are derived. She adds to the note of authenticity a very real ability in handling the English language and in presenting customs (that differ widely from our own) so clearly that they seem perfectly natural.

The title story is from the Yurok Indians. It is a sort of Yurok combination of Cinderella and Horatio Alger, Jr., the story of a poor and illegitimate youth from the wrong side of the tracks who rose to riches. The collection is very well calculated for indirect service to mental hygiene in demonstrating that there are many forms of social organization and many ideals of conduct which can claim validity with our own. The stories of "Butterfly Man" and of "Loon Woman" are of particular interest to the psychiatrist.

**The Roots of Psychoanalysis and Psychotherapy.** By S. A. SZUREK. 121 pages. Cloth. Thomas. Springfield, Ill. 1959. Price \$4.25.

The author collects thoughts on psychoanalysis and psychotherapy that are by no means new. The reviewer finds the purpose of the book obscure: It is too banal for the specialist, and too complex for the nonspecialist.

**The Szondi Test.** By LIPOT SZONDI, M.D.; ULRICH MOSER, Ph.D., and MARVIN W. WEBB, A.M., Ed.D. 309 pages including index. Cloth. Lippincott. Philadelphia. 1959. Price \$12.00.

The Szondi test has been interesting an increasing number of American psychologists and psychiatrists who have been handicapped by lack of both adequate text material and adequate discussion in English.

The present book covers the test, illustrating the material, giving the determinants and explaining the rationale. It is co-ordinated with a discussion of Schicksal Analysis. Szondi calls it psychoshock therapy. He considers it the depth psychology of the familial unconscious. Moser remarks that schicksal analysis has "created a new theory of drives that is supported by both geneology and the freudian theory of drives."

*The Szondi Test* is an introduction to the Szondi test method, a discussion of its philosophy, a compilation of interpretations, a report of scientific findings and an outline of therapeutic methods. Szondi depth analysis has its own terminology and its own interpretation of Freudian and Jungian theory as well as Szondi's own theory of the familial unconscious. In the preface, the authors express the belief that the student of this work "may reasonably expect" to acquire a basic understanding of the rationale of the Szondi test, become competent in applying and interpreting the test, acquire the basic knowledge to comprehend "szondian" periodical literature, acquire enough knowledge of szondian depth psychological experimental designs to pursue problems of validation and reliability, and finally to attain an orientation to make Szondi's more extensive works comprehensible.

Considering the increasing use of the Szondi test and of Szondi's terminology, this book would appear to belong in every psychiatric or psychological library.

**Trifluoperazine.** Clinical and Pharmacological Aspects. By 44 contributors. Introduction by HENRY BRILL, M.D. Cloth. 219 pages, with illustrations, 35 tables, bibliography and index. Lea & Febiger. Philadelphia. 1959. Price \$3.50.

This monograph appears to be what the clinician needs to know about the properties, the administration and the effects of trifluoperazine in psychiatric conditions. All but one of the 25 papers are original (presented here for the first time); they cover the field thoroughly from animal

experimentation to clinical appraisal and a most thorough discussion of side effects.

Brill reviews the salient points of the contributions in his introduction, remarking, "Because of the potential benefits the drug may bring, and because of the potential harm that may result from its misuse, it would seem important that trifluoperazine's advantages and disadvantages be brought to the attention of physicians as quickly as possible. With trifluoperazine—as with any new drug—there is a considerable gap between existing knowledge and published information. This monograph should help to close that gap."

The consensus of the contributors appears to be that the advantages of trifluoperazine considerably outweigh its disadvantages. Rudy, Rinaldi, Costa, Himwich, Tuteur and Glotzer contribute a chapter on "The Use of Trifluoperazine in the Treatment of Acute and Chronic Psychotic Patients." They conclude: "In our estimation, trifluoperazine is the most potent of the phenothiazine derivatives." Brooks' caution may be cited, "Trifluoperazine is a very powerful agent whose use demands considerable care and individualization of dosage." Brill notes that "parkinsonian reactions; dysknetic syndromes and akathisia" are the side effects most frequently reported. The contributors report uniformly that control of undesirable side effects is both quick and easy.

The material presented in this volume is from major research and clinical services. The general authorship is impressive, and the level of work and its presentation is high.

**Autonomic Imbalance and the Hypothalamus.** By ERNST GELLHORN, M.D., Ph.D. 300 and XIV pages, 101 figures, 13 tables. Cloth. University of Minnesota Press. Minneapolis, Minn. 1957. Price \$8.50.

This very-well-printed monograph describes the experiments in which Gellhorn has taken part, during his studies on autonomic imbalance and the hypothalamus.

In consideration of the fact that in interpersonal relationships many decisions are determined not so much by the actual event as upon the mood which prevails at the time the event occurs, it is intriguing to find experimental neurophysiological explanations that correspond to such an idea. Gellhorn calls the neurophysiological state that determines the type of response to the same stimuli or drugs, sympathetic, parasympathetic, sino-aortic or autonomic *tuning*, excitability or imbalance. His experiments concern not only the autonomic system but the hypothalamus and cortico-thalamic connections.

Gellhorn divides his book into three major divisions: experimental investigations, review of results and clinical application, summary and conclusions. He preceeds these by a short preface and follows them with an

epilogue in which he philosophizes on psychophysiological (organic) relationships. The bibliography contains 330 references. There is a three-page index.

Gellhorn's text is heavily weighted on the organic neurophysiological side. It is important from the standpoint of autonomic functions. These may be fundamental to the understanding of mental illness and the effect of ataractic drugs.

**The Sleepwalkers.** A History of Man's Changing Vision of the Universe. By ARTHUR KOESTLER. 624 pages including index. Cloth. Macmillan. New York. 1959. Price \$6.50.

This is a surprising volume to come from a novelist and essayist whose previous contributions have been largely political-economic. The present book is a history, from the frame of reference of personality study, of the great cosmologists whose theories have shaped man's changing views of the universe. Koestler starts with the Egyptians and proceeds through the Greeks and the theorists of the Middle Ages. Five-sixths of his book, however, is concerned with the four men who were chiefly responsible for today's outlook on the universe: Copernicus, Tycho de Brahe, Kepler and Galileo. These men, says Koestler, made their advances in spite of their cramping personalities and by a process which Koestler seems to feel was practically a controlled schizophrenia.

Copernicus, as Koestler pictures him, was an ultra-timid man who had to be urged into making public a theory he knew to be unsound. (He appears to have been convinced that the sun was the center of the universe, but he appears also to have been unconvinced of his own faulty explanations of planetary motions.)

Tycho was the prototype of the cautious collector of data; but he failed to interpret correctly the tremendous amount of data he amassed.

Kepler had an *idée fixe* which, however, did not interfere with accurate computation of planetary orbits from Tycho's data.

Galileo was a boaster, a pretender to priority in other people's discoveries and a quarrelsome character. His self-damaging tendencies brought about the rift with the Church which is so often misrepresented in sketchy histories of science. The Church, Koestler thinks, would have been happy to leave Galileo alone, and many churchmen who were astronomers agreed with his basic tenets, but Galileo pursued a course of provocation and insult until the clash was inevitable.

The reviewer recommends this book highly, not as a scientific character study but as a most provocative and erudite discourse. The reviewer, incidentally, would like to find a psychological explanation for why otherwise careful writers appear to go into panic states when they encounter mathematics. He reviewed a recent book in which a mathematician stated

that  $10^2$  is 10 multiplied by itself *twice*. In the present book, Koestler takes up Kepler's Third Law of planetary motion. He discusses it in terms of cubes and squares; then he gives an example in terms of square roots and cubes—a process which may be legitimate, though it should be explained. But in the course of it he announces, "the cube of 9 is 27."

**Creative and Mental Growth.** Third edition. By VIKTOR LOWENFELD. xxii and 541 pages. Cloth. Macmillan. New York. 1957. Price \$5.90.

Creative expression is as differentiated as are individuals; and in *Creative and Mental Growth*, Viktor Lowenfeld attempts to show how the child's general growth is tied up with his creative development. He succeeds well in indicating that a child's creative expression during specific stages in his mental and emotional growth can only be understood and appreciated if the general causal interdependence between creation and growth is understood. He shows methods of approach in art education based upon psychological relationships between creation and creator on the different age levels.

The author's extensive contact with teachers throughout the nation and his desire to include new knowledge, the results of new experiments, and their application to teaching, make this third edition particularly functional and significant. The book is not planned for use in its totality, but is designed so that parts will be found useful by any teacher anywhere. To the author, the meaning of art for education is that art is education in all its mental, emotional, and spiritual implications; that it is largely responsible for attitudes and actions.

It should be stressed that *Creative and Mental Growth* does not merely offer a single approach to freeing children and adults in their creative potentialities, or to making them more sensitive toward themselves and their environment. Lowenfeld writes brilliantly and comprehensively on the creative process and extends the frame of reference of art education in terms of the psychology of creativity. He points out also that one of the most important indications of emotional growth in a child is the child's flexibility, and that this can best be noted in the frequent changes in the child's concepts. A child who reacts toward meaningful experiences in an emotionally sensitive way, the author appropriately states, will show this emotional sensitivity in his art work.

Lowenfeld's *Creative and Mental Growth* is a remarkable publication for its comprehensiveness, wealth of information, and emphasis on the creative impulse in individuals—and for its many illustrations and references. It is recommended highly for its over-all excellence.

**Rings of Glass.** By LUISE RINSER. 176 pages. Cloth. Regnery. Chicago. 1958. Price \$3.75.

The author attempts in this novel to recapture thoughts and feelings of a little girl, and fails because of lack of psychological knowledge, or even insight. The reviewer feels that a few poetic passages do not compensate for the fact that childhood is incomprehensible without understanding unconscious mechanisms.

**Psychotherapy by Reciprocal Inhibition.** By JOSEPH WOLPE. 239 pages. Cloth. Stanford University Press. Stanford, California. 1958. Price \$5.00.

This is an important book, and one that may mark a significant advance. For in it, Dr. Wolpe describes the theory and methods that, he reports, have led to remission or marked improvement in 90 per cent of his neurotic patients. Not only is the percentage of success extraordinary, but the period of therapy is relatively short. More than half of his successfully treated patients required less than 30 hours of therapy.

Wolpe's therapeutic methods stem from learning theory, that branch of psychology that deals with the acquisition and extinction of responses. Wolpe is not merely familiar with learning theory, he has also made significant contributions to it.

In common with most other therapists, Wolpe assumes that anxiety is basic to neurotic behavior, which, despite its unadaptiveness, is remarkably persistent. It is persistent because anxiety, the root of the behavior, is difficult to eliminate. The essence of Wolpe's contribution is his formulation of the principle of reciprocal inhibition. This states: "If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety will be weakened."

Wolpe first demonstrates the validity of the principle experimentally, by inducing and curing experimental neuroses in cats. He then develops methods of applying the principle in ordinary psychiatric practice. These techniques are various but are fairly simple and can easily be learned and utilized by psychiatrists.

If Wolpe's degree of therapeutic success is duplicated by other therapists, his contribution may be acclaimed as one of the most significant to be made to psychiatry in our generation. Even if his results are not completely corroborated, the book represents an important bridge between the fields of psychiatry and psychology.

**History of American Medicine.** FELIX MARTI-IBANEZ, M.D., editor. 181 pages including index. Paper. MD Publications. New York. 1959. Price \$4.00.

This is an unusual symposium in that it could be used as an elementary textbook, as a desk book for ready reference or as a source for supplementary reading in the history of medicine. The contributions cover medical history in this country from the earliest colonial times to the present. They are well-presented, well-organized and well-edited and the book is cordially recommended.

**Lady Chatterley's Lover.** By D. H. LAWRENCE. 368 pages. Cloth. Grove. New York. 1959. Price \$6.00.

*Lady Chatterley's Lover*, as D. H. Lawrence originally wrote it, has been violently controversial for 30 years. It has been circulated in editions printed in Italy and Japan and sold under the counter in the English-speaking world as pornography. The present edition by Grove Press is the first to be offered, openly and frankly, to the American public—and it has encountered trouble.

The reviewer thinks this book is extremely important; thinks that if it is pornography (and it may be), its purpose is not prurience; and thinks it is as significant to the psychologist, psychiatrist or sociologist as to the student of literature. The outlines of Lawrence's own life and of his personal neurotic problems are well known. It is not fantastic to see in *Lady Chatterley's Lover* an expression not only of his experiences and emotions, but the setting down of a personal creed.

Lawrence wrote with the deliberate use of the common sex-words which have been outlawed for centuries. He also was exceedingly explicit in descriptions of coitus. Even today's outspoken fiction hardly equals this work of 30 years ago.

But Lawrence wrote with a purpose, however well he succeeded, which this reviewer agrees—as Mark Schorer indicates in his introduction—is almost religious. One of his characters says: "It is the one insane taboo left; sex as a natural and vital thing. . . . You have to snivel and feel sinful or awful about your sex, before you're allowed to have any."

Lawrence was a fervent social reformer. While Schorer makes it plain that the two principal characters of *Lady Chatterley's Lover* are not precisely those of Lawrence and his wife, a parallel in the situation cannot be obscured: a love affair between a man of the people and a lady aristocrat.

*Lady Chatterley's Lover* is material for unlimited psychoanalytic inquiry and speculation. It is comment enough on that point merely to indicate it. Lawrence, whatever, his own psychological make-up, which was certainly not the theoretical "normal," was fanatically dedicated to moral and social reform. His most controversial work is, therefore, of broad

sociological interest, as well as of interest in its revelation of personal psychology. What Lawrence was fighting was the sex-repressive super-ego; and he may have held the mistaken belief that it could be directly modified through the intellect—by an appeal to reason which would strike the chains from enslaved instinct. It perhaps should be remarked that, however it has come about and with whatever cost in neuroses, some of the changes he sought seem slowly to be developing. Without at least some progress in this direction, it seems unlikely that this edition of *Lady Chatterley's Lover* ever could have been issued.

It has not, of course, been received with precisely universal acclaim. The postoffice has prohibited its mailing as obscene; and the question is now in litigation. That hardly affects the conclusion that this novel is of interest and importance to the social scientist. Nor does the question of obscenity enter into this. Whether copies will continue to be readily available is another matter.

**Basic Issues in Psychiatry.** By PAUL V. LEMKAU, M.D. vii and 106 pages. Cloth. Thomas, Springfield, Ill. 1959. Price \$3.50.

These short and comprehensive lectures on psychiatry were delivered before an audience of physicians as part of the postgraduate medical education program of the University of Florida, accredited by the American Academy of General Practice. They cover in brief outline an authoritative description of what psychiatry is today and of what its present pressing problems are. The author is a psychiatrist, teacher and writer who is professor of public health administration at the School of Hygiene and Public Health, the Johns Hopkins University, and is thus in an advantageous position to view the whole broad psychiatric field.

Lemkau outlines, as today's basic issues, the problem of the size and range of mental health questions, the prevention of central nervous system damage in the population, the prevention of psychogenic illness, the question of treatment, and the question of administering psychiatric programs. On the first and the last issues, he speaks with unusual authority.

The discussions in this book were intended for general medical people, not for psychiatrists, but the reviewer thinks that the psychiatrist may find them of considerable use. They present a bold sketch of a scene that, to the specialist, is often obscured by detail; and the specialist may thus find them of value as refresher orientation. He may also find them of use as a general guide for explanation, to nonspecialist medical people or general readers, of current psychiatric problems: their extent, measures of prevention, methods of treatment and the question of providing and administering the psychiatric facilities needed for our present population. Most of the material presented is perfectly comprehensible to the well-informed layman, and the book can be recommended unhesitatingly for general reading.

**The Lost World of the Kalahari.** By LAURENS VAN DER POST. 279 pages. Cloth. Morrow. New York. 1958. Price \$4.00.

Mr. van der Post's narrative is primarily a travel book. It is rather a record of his own difficulties in finding surviving specimens of the vanishing Bushman people than it is a work of ethnology. There is, however, enough material in the way of social anthropology to make the book intensely interesting to the scientist. The Bushman's way of life is apparently somewhat akin to that of our own very remote ancestors; the Bushmen have nearly disappeared; and this chronicle, brief as it is, is, therefore, important. It is also exciting writing.

**Rivers in the Desert.** By NELSON GLUECK. 302 pages including index. Cloth. Farrar, Straus and Cudahy. New York. 1959. Price \$6.50.

Nelson Glueck has written a pre-history and a history of the Negev Desert, which is not so bleak a land as it has appeared to be. Glueck adds to the archeological evidence—much of which he himself is responsible for—the evidence of history and his own testimony as a traveler in this neglected area of southern Palestine. His work is an account of what men have done and what men still can do under the most adverse circumstances. It is a study in the character and the folkways of the ancient and modern peoples who have adapted themselves and their societies to lives in a supposedly arid region. If it is a little difficult at times to tell whether the author is writing as an archeologist, a rabbi or a simple traveler, the fact adds to the comprehensibility and readability of his book for the non-specialist reader. Glueck and other scientific workers appear to have disposed of the theory that climatic changes were the basis for alternate cultivation and abandonment, not only of the Negev, but of much of the Trans-Jordan area. The periodic devastations of these lands can be attributed to the savage behavior of man. The book is worth any social scientist's time, and is a fascinating story besides.

**A History of Sexual Customs.** By RICHARD LEWINSOHN, M.D. 424 pages including index. Cloth. Harper. New York. 1958. Price \$5.95.

*A History of Sexual Customs* is a translation from the German text of a writer who is both a doctor of medicine and an expert in political science. It covers very concisely the general outline of what is known about sexual customs from remote times to the present day—overt behavior. The focus is on western civilization, and the scope of the book covers sex in evolving society and historical sexual organization as well as the broad aspects of sex in religion. Lewinsohn surveys and presents material from sources which range from Malinowski to Westermarck and Briffault. The material presented is generally well-chosen and the author's interpretations are those generally accepted. They are, of course, on the ethnological, not on the deeper psychological, level. The text reads very

smoothly and can be recommended for entertainment, general information and reference.

**The Case of the Attic Lover.** By ALAN HYND. 160 pages. Paper. Pyramid Books. New York. 1958. Price 35 cents.

This collection of "true murder cases" is in reportorial style—written without understanding of motivations. But one meets "the strangest people" (as the publisher announces), including a nymphomaniac who kept her lover stored away for 20 years in the attic.

**Psychology of Personality.** J. L. McCARY, editor. 383 pages including index. Paper. Grove. New York. 1956. Price \$1.95.

This book is comprised of various approaches to the study of personality, and includes Leopold Bellak's chapter on psychoanalytic theory; Raymond B. Cattell's on measurement of traits; George S. Klein's on a clinical perspective on perception and motivation; Margaret Mead's on a cross-cultural approach, and Nevitt Sanford's on the implications of the "Authoritarian Personality." David McClelland makes a heroic effort in the last chapter to tie all the ends up somewhat and integrate the widely divergent views; he succeeds in coming up with a fairly well-organized and broadened psychology.

Bellak's chapter succeeds in presenting the gist of psychoanalysis, although by his own admission his write-ups of different concepts are of uneven quality, some of them with over-simplified schemata that are wasted on the more sophisticated reader. Klein concisely outlines the history of perception-motivation research, and describes and classifies previously neglected phenomena that are critically involved in human responsiveness.

Sanford answers adequately those critics of his study, *The Authoritarian Personality*, who found the research methods used to be less than well-organized and systematized. This study is only meant to be exploratory, and is notable for creative and original thinking. Sanford admits that it is of low order theoretically, that it is of the "ad hoc" variety. Cattell's oracular presentation of factor analysis as the one acceptable scientific approach, should have been edited down. There is little value in his insistence that psychoanalysis is an elaborate theory that only served to keep psychologists in business during all the years when they had no real stock in trade, or in his reference to the interpretation of projective tests as crystal-ball gazing. Every other contributor to this volume is more generous to those holding different theories from his own. However, Cattell does outline factor analysis with incisive clarity and without too much statistical detail. Margaret Mead charms and enlightens with her astute and wide-range observations and insights—even into such homely and mundane universals as modes of transporting babies. The total impact of the divergent views presented in this book is illuminating and stimulating.

**Closed Ranks.** An Experiment in Mental Health Education. By ELAINE and JOHN CUMMING. 192 pages, including two appendices. Cloth. Harvard University Press. Cambridge, Mass. 1957. Price \$3.50.

Most Americans have unbounded faith in the power and magic of education. We tend to believe that we can educate problems out of existence. There is some justification, as well as need, for such a faith, but its unqualified acceptance is, perhaps, a bit naïve. The Cummings' valuable little book is, among other things, a case study in the development of sophistication.

The book by the Cummings (he is a psychiatrist, she a sociologist) is a detailed report and analysis of an intensive six-month program in mental health education. The aim was simple—to change the attitudes of the residents of a small town about mental illness. The attempt ended in failure. Not only did the attitudes remain unchanged, but the educators generated anxiety and hostility in the townspeople. Surely this is a dismaying result, and if the authors were content merely to report it, the book would have limited value. Fortunately, they found the outcome not only disturbing but challenging and the chief virtue of the book is their penetrating sociological analysis of the reasons for the failure.

The Cummings believe that attitudes they found toward the mentally ill formed a coherent pattern of beliefs, which helped to maintain the orderliness and stability of social existence. The elements of this pattern were the "denial, isolation and insulation of mental illness"; and the threat posed by the mental health education program to the integrity of this belief-system resulted in the failure of the program. It is a provocative analysis.

**The Drowning-Stone.** By HUGH FOSBURGH. 189 pages. Cloth. Morrow. New York. 1958. Price \$3.00.

This is a tensely dramatic story of a manhunt in the remote corners of the Adirondack Mountains. The story focuses on Sam Bentley, the game warden, who must join the hunt against his life-long friend. The reviewer thinks the psychology and writing are both excellent, in a truly fine novel.

**Der Psychiater** (The Psychiatrist). By PROF. DR. KURT KOLLE, director of the Neuropsychiatric University Hospital of the Ludwig Maximilians University in Munich, Germany. 57 pages with preface and bibliography. Cardboard. Thieme. Stuttgart. 1959. Price \$1.30.

Professor Kollé, distinguished physician and neuropsychiatrist, teacher and spokesman of German psychiatry, offers—in this academic address at the re-dedication of the Neuro-Psychiatric University Hospital at Christian-Albrechts University in Kiel—his conception of the status of psychi-

atry in our times. But this small, beautifully-printed book is more than an inventory and balance of our science and profession. It sets forth the maxims of a great physician, humble and strong in his devotion to science and humanity. Kolle confesses his belief in the inseparable cohesion of neurology and psychiatry, of medical science and medical practice. And yet he is foremost a psychiatrist and a human being.

For Kolle, the psychiatrist is the man who serves the human being with knowledge and experience and humility as a fellow human being in all his conflicts—without limitations by categories, without prejudice or dogmatism. He is by no means uncritical; his address is self-effacing, yet gives, at the same time, a very critical summing up of his own and of world experience in our young science of psychiatry. One can only wish that this small booklet could be read by every psychiatrist.

**Reading: Chaos and Cure.** By SIBYL TERMAN and CHARLES CHILD WALCUTT. 285 pages including index. Cloth. McGraw-Hill. New York. 1958. Price \$4.75.

The authors ably present a strong case for learning to read by the phonetic method. Indeed after reading the book, the reviewer is inclined to wonder why there is even a murmur of dispute as to the superiority of phonetics over the sight method. The struggle with some professional educators may be a long one, but the authors point out that many schools have already reverted to phonetics. To this reviewer's mind, the quicker, the better. Included in the book are instructions for teacher or parent as to how the phonetic method should be taught. These are simple and easy to follow.

**The Mischief.** By ASSIA DJEBAR. 113 pages. Cloth. Simon and Schuster. New York. 1958. Price \$2.50.

This slim novel was written by a westernized Moslem young woman about other westernized Moslem young people. The reviewer does not know if the writer is conscious of the mechanism, but her book is a fine study of psychic masochists who seek their own misfortunes.

**The Anatomy of the Nervous System.** Its Development and Function. By STEPHEN WALTER RANSON, M.D., Ph.D. Revised by SAM LILLARD CLARK, M.D., Ph.D. 622 pages with 434 illustrations, 11 in color; laboratory outline of neuroanatomy; bibliography; and index. Cloth. Saunders. Philadelphia. 1959. Price \$9.50.

This tenth edition of a standard text and reference work that was first published under Dr. Ranson's authorship in 1920 has been largely revised and is considerably enlarged. The work has been brought up to date, chapter by chapter and section by section, by the inclusion of mate-

rial that has become available since publication of the ninth edition in 1953; it contains 622 pages compared to 581 in the ninth edition; the index is very usefully expanded from 27 pages to 38; and there are six more pages of bibliography.

The volume follows the chapter divisions and subdivisions of the preceding edition, with the laboratory outline covering directions for dissection and study in an order correlated with the preceding chapters. The terminology now follows generally that adopted by the International Anatomical Nomenclature Committee in 1955, with "accepted practise" the guide for terms not on the committee's list and some other modifications made to permit study of the cerebellum from a comparative and embryologic point of view. The terminology of the ninth edition was based generally on the English version of the Basel anatomical terms of 1895. The illustrations of the new edition have been thoroughly revised, with substitutions of a number of clearer, new anatomical drawings and of new figures based on electron micrographs for a number of the old figures.

Dr. Clark has revised the text, not only to bring the material up to date, but to widen the perspective and improve the orientation of the student as well. The resulting fine volume is a worthy successor to the preceding edition and will undoubtedly find as useful a place in teaching and on the reference shelf.

**Design for Mental Health.** New York State Department of Mental Hygiene. Unpagd. Paper. 1958.

This well-illustrated booklet covers the official activities of the New York State Department of Mental Hygiene from aid to community mental health projects to research. It is reviewed here because many psychiatrists and psychologists should find it useful in explaining out-patient, hospital and school facilities to relatives of prospective patients.

Single copies will be supplied free on request to: Office of Mental Health Education and Information, Department of Mental Hygiene, 240 State Street, Albany, N. Y. Copies are available in limited quantities to recognized agencies and organizations within New York State.

**Mannerisms of Speech and Gestures in Everyday Life.** By SANDOR S. FELDMAN, M.D. 301 pages. Cloth. International Universities Press. New York. 1959. Price \$5.00.

A New York psychoanalyst, quoted on the dust cover as an advance reader of Dr. Feldman's work on mannerisms, remarks that it is a logical continuation of Freud's *Psychopathology of Everyday Life*. The reviewer agrees.

Dr. Feldman interprets such things as "By the way," "It goes without saying," "Er—er—er," "Your friend, this s.o.b.," and "We like it this

way." Among gestures, he discusses putting the arms akimbo, crossing the fingers, knocking on wood, nose-thumbing and making the "fig."

Few would quarrel with the tenet that these expressions and gestures have unconscious determinants. Feldman lists a choice collection of them, frequently illustrating with clinical examples from his own practice and that of other analysts, and with examples from "normal life" and literature. He would doubtless be the first to disclaim that the interpretations he gives are the only possible or only probable ones. His book, of course, will be open to the possibility of misinterpretation here by students and general readers. Others will find in it much illumination and much practical example in the way of interpretation.

**Can Man Be Modified?** By JEAN ROSTAND. 105 pages. Cloth. Basic Books. New York. 1959. Price \$3.00.

Jean Rostand is one of the world's leading experimental biologists. The son of Edmond Rostand, he is also an unusually good writer. His small book *Can Man Be Modified?* is an exploration from the biologist's point of view of the possibility of deliberate improvement in the human race. It is also an eloquent plea for the love of truth because it is truth. Rostand believes that "in the future, we shall learn how to make human hereditary characteristics mutate in a direction that will be both predictable and advantageous."

The psychiatrist will be particularly interested in the author's cautious discussion of the possibility of mental and emotional improvement.

**Love, Skill and Mystery. A Handbook to Marriage.** By THEODOR BOVET. 183 pages. Cloth. Doubleday. New York. 1958. Price \$3.50.

This is a translation of a book by a Swiss physician who is considered, by many persons, to be a wise and skillful marriage counselor. It will not, probably, give the doctor, the psychiatrist, the psychologist, or the marriage counselor, new information, but it does give a style of presentation which should be valuable.

**Sigmund Freud and the Jewish Mystical Tradition.** By DAVID BAKAN, Ph.D. 326 pages including index. Cloth. Van Nostrand. New York. 1958. Price \$5.50.

David Bakan's thesis is that Freud was prepared for his life work in the development of psychoanalysis by a rich background of Jewish mystical tradition and experience. Freud himself referred, on various occasions, to his Jewish cultural background, and numerous commentators have applied Freudian principles in an effort to trace instances of its cultural and psychological significance. Professor Bakan believes that there was a

more direct influence than has generally been recognized. The reason for Freud's own lack of emphasis, the author thinks, was the strong anti-Semitism of European general and scientific circles at the time psychoanalysis was being developed.

Dr. Bakan, therefore, has gone into the traditions and tenets of Kabbala and other Jewish mystical lore, to find parallels to psychoanalytic theory and procedure. He believes that the techniques of interpretation, the psychoanalytic theory of bisexuality, the basis for the interpretation of dreams and a number of psychoanalytic concepts about sex were foreshadowed in the traditions of Jewish mysticism.

The argument is extremely persuasive and it would require a critic intimately acquainted, both with Kabbala and with the origins of psychoanalysis, to estimate how much weight should be given to it. This reviewer can only say that the book should be of considerable interest to all psychoanalysts, to other followers of the Freudian theory, and in particular to students who cannot themselves visualize Freud in the context of the Jewish mysticism with which, at the least, he must have been acquainted.

**Star Wormwood.** By CURTIS BOK. 228 pages. Cloth. Knopf. New York. 1959. Price \$3.95.

Judge Bok writes in protest against a criminal and penal system based on "vengeance." His book is framed around the crime, trial and execution of Roger Haiké who was convicted in 1931 of a murder which was followed by cannibalism. Comment on the three aspects of the case is based on lectures delivered by the author at the University of Virginia Law School.

Judge Bok is unalterably opposed to capital punishment. His view is not too far removed from that of prevailing psychiatric opinion, although many psychiatrists would doubt the practicability, now or in the near future, of his proposals. Bok believes that criminals are sick men "socially or medically or both," and that "To execute sick men or merely to incarcerate them is indeed like burning witches or chaining them to the wall." For "vengeance," the author would substitute medical treatment.

It probably should be remarked that Judge Bok, not surprisingly, has respect for psychiatric testimony—and no use for the M'Naghten Rule.

**God and Freud.** By LEONARD GROSS. 215 pages. Cloth. McKay. New York. 1959. Price \$3.95.

The author of this book is a professional writer who is interested in, and well informed in, psychiatry and mental hygiene. He has attacked the belief that there is conflict between psychiatry and religion by inquiries in three religious fields, Roman Catholic, Protestant and Jewish; and he treats of psychiatry as generally oriented on Freudian principles. He cites, among others, the example of Father William J. Devlin, S.J., M.D., a practising psychiatrist. He cites Father Devlin on Freud. "Freud

had the right idea operationally—that people act a certain way as a consequence of their experiences and desires,” Father Devlin says. “But he used the wrong word. He said sex gave people thrust. That’s too simple. It’s not true. We say that love or fulfillment—of which sex is only a part—is what gives people thrust.”

Gross notes that Dr. Devlin was influenced by Father Thomas Verner Moore, O.B.S., M.D., also a priest and psychiatrist. The influence of such practitioners, the author thinks, should go far to counter such attacks as those of Bishop Fulton J. Sheen. Gross goes on to show Protestant and Jewish examples of co-operation between psychiatry and religion. His book is an informed, useful and apparently reliable survey of the field. Either clergymen or psychiatrists should be able to recommend it for general reading, and a good many psychiatrists should find it informative and useful in dealing with both patients and the clergy. The reviewer thinks it is an important contribution to mental hygiene and that it would make excellent orientation material for any psychiatrist in relation to dealings with patients, relatives and clergy of the principal religious faiths.

**Psychoanalysis of Behavior.** By SANDOR RADO. 357 pages. Cloth. Grune & Stratton. New York. 1956. Price \$7.75.

**Changing Concepts of Psychoanalytic Medicine.** SANDOR RADO and GEORGE E. DANIELS, editors. 240 pages. Cloth. Grune & Stratton. New York. 1956. Price \$6.75.

Both of these volumes deal with the modifications of the “Columbia school,” at bottom Rado’s suggestions concerning changes from Freud’s “classical psychodynamics” to “adaptational psychodynamics.” It is practically impossible to get a precise picture from these books of what the new school actually does clinically. It is clearer what the school is against. The difficulty may be a terminological one: “Even though the introduction of numerous new terms makes communication difficult at first, this is a crucial step. . . .” This crucial step seems not yet successfully taken in either volume (in the second, 23 contributors are included). The most interesting part of Rado’s papers are those he wrote while still adhering to Freud’s technique.

**Self Condemned.** By WYNDHAM LEWIS. 407 pages. Cloth. Regnery. Chicago. 1955. Price \$4.00.

This novel is recommended as a primer of psychic masochism, providing the reader is familiar with the technique, consisting of unconscious provocation, extensive use of pseudo-aggression and whining after receiving the unconsciously asked-for kick in the jaw. Without previous knowledge of this mechanism, the reader is lost in this well-written novel: Neither author, nor hero, has any inkling of it.

**Young Man Luther.** By ERIK H. ERIKSON. 288 pages including index. Cloth. Norton. New York. 1958. Price \$4.50.

Erik H. Erikson is a psychoanalyst, teacher and writer. In *Young Man Luther*, he has written a psychological study of the great religious reformer.

There has been much criticism of such psychiatric and psychoanalytic attempts at biography and there will doubtless be plenty of criticism of this one, some possibly on the grounds of underestimating biological as opposed to social factors. Erikson sees Luther as very much influenced by his times and, of course, by his monastic experience. Luther, the author thinks, was impelled to attempt to restore, in the terms of religion, the "basic trust" which man has in early infancy. He sees him, despite his rebellion against the church of Rome, as a basically authoritarian figure.

Luther thought serfdom was consistent with the scriptures. He believed no insurrection was ever right. In fact, says Erikson, "he promised rewards in Heaven to those who risked their lives in subduing insurrection."

Luther was an anal character. He suffered from constipation and urine retention. Erikson postulates that when his power of speech was freed from the infantile and juvenile captivity of the monastery he changed from a highly restrained and retentive individual into an explosive person. Luther had an "inner store of self-hate." His anxiety more than once came close to deep depression. When he was melancholy he expressed himself freely in words that can only be translated in four-letter anal terms.

Erikson's biography is an attempt at a psychological chronicle rather than an attempt to find psychopathology. He traces Luther through the basic crises which the normal man must meet in life. Luther, says Erikson, was the prototype of a "new man, husband and father." Sir Thomas More, he points out, was another such man who died a martyr. "... but Luther had tasted deeper personal conflict and more revolutionary revelation, and at the end, he was not always himself. 'When I am well again, I see it all nicely,' he said."

**Men, Molds, and History.** By FELIX MARTÍ-IBÁÑEZ, M.D. 114 pages including index. Cloth. MD Publications. New York. 1958. Price \$3.00.

Dr. Martí-Ibáñez presents here a second volume in the series of which *Centaur* is the first. It concerns the history of antibiotics and is concise, authoritative and informative. Dr. Martí-Ibáñez is an editor and writer as well as a physician, and he cannot escape entirely from any of his three professions. This book, for example, includes chapters on antibiotics and the problem of medical communication, and on words and research. For these alone, *Men, Molds, and History* is worth the attention of any physician.

**Freedom or Secrecy.** By J. R. WIGGINS. 226 pages. Cloth. Oxford University Press. New York. 1956. Price \$4.00.

A well-known journalist advocates freedom of the press at times that (in his opinion) restrict that freedom. His motto is James Madison's dictum: "Knowledge will forever govern ignorance . . . A popular government without popular information or the means of acquiring it, is but a prologue to a farce or a tragedy, or perhaps both."

**They Walk in Shadow.** By J. D. MERCER. 573 pages. Cloth. Comet. New York. 1959. Price \$5.95.

The author of this book is a layman, psychiatrically and scientifically, who—the dust cover states—is a "self-confessed, self-accepting ambisexual practitioner." The dust cover also suggests that the book "will be sought out not only by psychologists, psychiatrists, penologists, judges, social workers, legislators and policemen, but also by the general lay public. . ." The psychologist and psychiatrist will, indeed, be interested in the book as a fairly typical rationalization for homosexuality, which the author appears—naturally—to believe is genetically determined. It will be most regrettable, however, if the book has any appreciable circulation among the "general lay public," for it is another of these arguments calculated to impress the impressionable.

The author takes Kinsey's statistics at face value, and cites the not generally-accepted views of Albert Ellis with apparent great admiration, giving Ellis 10 notices in his bibliography. (It is only fair to state that Ellis says, "I cannot agree with many of his views on homosexuality.") Mercer's bibliography also includes André Gide, Krafft-Ebing, Edward Carpenter, Donald Webster Cory and John Aldington Symonds. He includes one book by Freud and no bibliographic citation at all for such a modern psychoanalytic student of homosexuality as Bergler. Mercer is contemptuous of psychoanalysis. He believes that many homosexuals are neurotic because of social objections to their way of life. He naturally does not recognize homosexuality as a neurotic symptom.

**The Psychodynamics of Family Life.** By NATHAN W. ACKERMAN. 365 pages. Cloth. Basic Books. New York. 1958. Price \$6.75.

The tone of the book is set on p. 27: "One may well raise the question whether these vocal and staunch supporters of the 'master' [the ironical quotation marks pertain to Freud] or the so-called 'revisionists' are the more truly loyal. I count myself among the revisionists." Having thus proclaimed his constitutional right to object, the author comes out with opinions, and here the trouble starts. The reviewer got an idea of what the author is against; what he wants and stands for seems hazy, confused, unclear.

**The Trial of Dr. Adams.** By SYBILLE BEDFORD. 245 pages. Cloth. Simon and Schuster. New York. 1959. Price \$3.75.

John Bodkin Adams, a fat, middle-aged, general practitioner in a resort town in England, was tried in 1957 for the murder of an aged patient more than six years before, in a proceeding that created a sensation on this side of the Atlantic as well as in Great Britain. The trial was not only the longest murder trial in the history of English justice (17 days) but was crowded with dramatic developments.

Sybille Bedford's account of it is painstakingly factual and is based on the testimony, of which she gives the high points verbatim. She has chosen her material with great care, and the result would be worthy of a stage melodrama. She is also plainly partisan—for the defense. The trial of Dr. Adams followed much malicious and prejudicial gossip and had as a factual basis a number of violations of laws and professional regulations. The running account of the trial should be of great interest to any medical practitioner; and the testimony should be of particular interest to any whose practice involves frequent prescription of narcotics—or of hypnotics, for that matter.

Dr. Adams was acquitted of murder after the defense had played havoc with the prosecution's witnesses. In his summing up, the judge had come very close to directing acquittal: "I do not think...that I ought to hesitate to tell you that...the case for the defence seems to me to be manifestly a strong one." Dr. Adams later admitted professional misconduct and was struck off the Register of Medical Practitioners.

This account of his trial is enlivened by vivid description and much brief but penetrating commentary. It is one of the most absorbing books of its sort that this reviewer has encountered.

**Of Love and Lust.** By THEODOR REIK. 623 pages. Paper. Grove Press. New York. 1959. Price \$2.45.

This book is a moderately-priced, paperback reprint of an important work first published in 1957. Theodor Reik was a pupil and a longtime friend of Freud, one of the non-medical analysts trained by Freud himself. *Of Love and Lust* is a compilation from three of his earlier works, plus some original material on the emotional differences of sex—an illuminating and rather philosophical discussion of differences in men's and women's behavior. It comprises part four of the present book. The other three parts are made up of selections from *A Psychologist Looks at Love*, and from *Masochism and Modern Man*; and of two essays in a symposium, *Why Are You Single*, compiled by Hilda Holland. Reik's work has always been distinguished for acute clinical observations and stimulating discussion. The present book can be recommended to the student or young practitioner at a price he can reasonably afford.

## CONTRIBUTORS TO THIS ISSUE

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**KARL R. BEUTNER, M.D.** Dr. Beutner is engaged in private psychiatric practice in San Francisco and Vallejo, Calif. He was formerly senior psychiatrist at Napa (Calif.) State Hospital. Born in Charlottenburg, Germany in 1919, Dr. Beutner is a graduate of Hahnemann Medical College in 1944. He interned in Philadelphia and Camden, N. J., then served a residency in Worcester, Mass. He was on the staff of Herrick Hospital, Berkeley, Calif. in 1950. He joined the staff of Imola (Calif.) State Hospital in 1951. Dr. Beutner is a member of the American Psychiatric Association and of numerous other professional associations, including the American Association for the Advancement of Science, the National Committee on Alcoholism, the American Psychosomatic Society and the American Anthropological Association. He is author or co-author of a number of scientific and popular publications, including several on alcoholism.

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**RUSSELL BRANCH.** Mr. Branch is a technical editor with the Stanford Research Institute, working on the research project for the United States Army Combat Development Experimentation Center at Fort Ord, Calif. A professional editor, he attended Cornell and Colgate and has done editorial work for *Time*, for Columbia Pictures and for the Hoover Institution on War, Revolution and Peace at Stanford University. He has published a neighborhood newspaper and written fiction.

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**PRISCILLA G. ILEM, M.D.** Dr. Ilem, born in the Philippines, is a graduate in medicine of the University of Santo Tomas in that country. After postgraduate work in the Philippines, she served an internship at Truesdale Hospital, Fall River, Mass. and then joined the staff of Marcy (N.Y.) State Hospital in 1956 as a resident psychiatrist. She is now finishing her residency there.

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**ANTHONY SAINZ, M.D.** Dr. Sainz, born in Havana in 1915, received his medical degree from the University of Havana in 1941. Besides his M.D., he holds a law degree and bachelor's degrees in both arts and science. Dr. Sainz is now in charge of the psychopharmacological research unit at Marcy (N.Y.) State Hospital. He has done research for the Ministry of Public Health of Cuba, the Finley Institute for Research of Havana and the University of Havana Medical School. He has been a medical director for UNRRA in the United States zone of occupation in Germany; and he was clinical director at the Mental Health Institute, Cherokee, Iowa, before joining the Marcy State Hospital staff.

PAUL H. HOCH, M.D. Dr. Hoch, psychiatrist and research scientist, is commissioner of mental hygiene of the State of New York, a position he has held since 1955. He had been principal research scientist in psychiatry at the New York State Psychiatric Institute since 1948. Born in Hungary in 1902, he was graduated in medicine from the University of Göttingen in 1926. He interned at Göttingen University Hospital, served as assistant physician there and in Switzerland, and then began his career in research at Göttingen. He gave up the position of first assistant physician in charge of the out-patient department and of the brain research division of the university clinic to come to the United States in 1933. Dr. Hoch was on the staff of Manhattan (N.Y.) State Hospital for nine years and was in charge of shock treatment there when he left in 1942 for service with the War Shipping Administration and as consultant to the United States Public Health Service. He returned to New York State service in 1943 as assistant clinical psychiatrist at the Psychiatric Institute, later becoming senior clinical psychiatrist and finally principal research scientist.

Dr. Hoch is author or co-author of numerous books and scientific papers, including a number of previous publications in *THE PSYCHIATRIC QUARTERLY*. He has been editor or co-editor of a number of books and is now associate editor of *Psychosomatic Medicine* and the *American Journal of Psychiatry*. He is professor of clinical psychiatry at the College of Physicians and Surgeons, Columbia University, and has held numerous other teaching positions. He is a fellow of the American Psychiatric Association, a fellow or member of various other professional organizations, and is certified in both psychiatry and neurology by the American Board of Psychiatry and Neurology.

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JAMES P. CATTELL, M.D. Dr. Cattell is assistant clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University. He is assistant attending psychiatrist at Presbyterian Hospital, New York City, and associate attending psychiatrist at the New York State Psychiatric Institute. Dr. Cattell, born in Ohio in 1916, received his M.D. from Harvard in 1942. He served an internship in Boston and residencies in army general hospitals and at the New York State Psychiatric Institute. He has had psychoanalytic training at the Columbia University Psychoanalytic Clinic. He is certified in psychiatry by the American Board of Psychiatry and Neurology, is a fellow of the American Psychiatric Association and a member of various other scientific organizations. He is the author of a number of scientific articles on psychiatric and psychoanalytic subjects.

**ALDO MORELLO, M.D.** Dr. Morello is professor of neurosurgery at the University of Palermo, Italy. A graduate in medicine of that university, he studied for some years in the United States. He came to this country in 1953 as a Fulbright fellow to serve a residency in neurosurgery at the New York University-Bellevue Medical Center on the service of Dr. Thomas I. Hoen. He was assigned later for three years of research at Central Islip (N.Y.) State Hospital where he is credited with having been instrumental in developing methods of neuroradiological diagnosis for neurosurgical techniques. He is a diplomate of the American Board of Neurosurgery. He is the author or co-author of scientific publications, including previous contributions to *THE PSYCHIATRIC QUARTERLY*.

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**FRANCIS J. O'NEILL, M.D.** Dr. O'Neill is senior director of Central Islip (N.Y.) State Hospital. He was born in Vermont and is a graduate of the University of Vermont and of the University of Vermont College of Medicine, where he received his medical degree in 1932. He interned at an army general hospital, was in private practice for a short time and then joined the New York State hospital system at Central Islip. He has been with the New York State hospital service ever since joining it, except for a period of World War II service in the navy and with the marine corps in the southwest Pacific. He served as psychiatrist in various grades and as pathologist before becoming director of Utica State Hospital in 1949. His promotion to the senior directorship and assignment to Central Islip came two years later. Dr. O'Neill is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, and a fellow of the American Medical Association.

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**THOMAS I. HOEN, M.D.** Dr. Hoen is director of neurosurgery, fourth division, Bellevue Hospital, New York City, and attending neurosurgeon at Central Islip (N.Y.) State Hospital. He is a graduate in medicine of Johns Hopkins in 1928 and is a diplomate of the American Board of Neurosurgery. He had training in neurosurgery under Harvey Cushing in Boston, and Wilder Penfield in Montreal, then was chief of neurosurgery and of the neurosurgical service at St. Luke's Hospital, Montreal. He served at other hospitals in Canada, New Jersey and Connecticut before moving to New York City. He is professor and chairman of the department of neurosurgery at the New York University-Bellevue Medical Center. He is a captain in the inactive reserve of the navy. He has contributed previously to this *QUARTERLY*.

ROY M. MENDELSON, M.D. Dr. Roy Mendelson, co-author of a study on massive doses of chlorpromazine in this issue of *THE QUARTERLY*, was a ward psychiatrist at the Veterans Administration Hospital, St. Cloud, Minn. when the study was done. He is a native of Chicago, and a graduate of the College of Medicine of the University of Illinois in 1951. He was in the Menninger School of Psychiatry from 1952 to 1955 and was a ward psychiatrist at the Veterans Administration Hospital, St. Cloud, from 1955 to 1957. He is now a fellow in child psychiatry at the Menninger Foundation.

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ALLEN S. PENMAN, Ph.D. Dr. Penman was chief psychologist at the Veterans Administration Hospital, St. Cloud, Minn. from 1953 to 1957, when he left to join a firm of psychological consultants; he is now a partner, in charge of the concern's Toronto office. Born in Williston, N. C., in 1920, he attended the University of Kentucky in 1938 and 1939, then transferred to the University of Illinois, where he completed a pre-medical course before enlisting in the army air force in 1942. When he was discharged in 1945, he returned to the University of Illinois, where he received his bachelor's degree in 1947, his M.S. in clinical psychology in 1948, and his Ph.D. in clinical psychology in 1951. He became a trainee at the Veterans Administration Hospital at Danville, Ill., while he was still at the university. He moved to the St. Cloud hospital in 1951, became chief psychologist there two years later, and remained there until he left to enter private professional work. Dr. Penman is married and has two sons; he is a golfer, hunter, fisherman, and a devotee of sports in general.

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BURTRUM C. SCHIELE, M.D. Burtrum C. Schiele was born on October 22, 1904 in Colorado Springs. He received his A.B. degree in 1927 from Colorado College and his medical training at Colorado University. He was married in 1935 to Evelyn A. Pederson; they have three children.

Dr. Schiele interned at Ancker Hospital, St. Paul, Minnesota, from 1931 to 1932 and was the recipient of a Commonwealth Fund fellowship in psychiatry at the Colorado Psychopathic Hospital, Denver, from 1932 to 1934. He was assistant resident and resident psychiatrist at the Payne-Whitney Psychiatric Clinic in New York City from 1934 to 1937 and was simultaneously assistant psychiatrist and instructor of psychiatry at Cornell University Medical School. In 1937, Dr. Schiele became assistant professor of neurology and psychiatry at the University of Minnesota and in 1948, professor of neurology and psychiatry and chief of adult inpatient psychiatric service, positions he holds now. Since 1948 he has been the psychiatric consultant to the Veterans Administration Hospital, St. Cloud, Minn.

Dr. Schiele has been active in such civic agencies as the university Y.M.C.A. committee of management, and the Minnesota Mental Hygiene Society, and he has been a member of the Governor's Advisory Council on Mental Health in Minnesota. Dr. Schiele's organizations include the Minnesota Society for Neurology and Psychiatry, of which he was president, 1950 to 1951; the American Psychiatric Association; and the Central Neuro-Psychiatric Association. He has published numerous articles on various aspects of psychiatry. He is certified by the American Board of Psychiatry and Neurology in both specialties.

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THOMAS S. SZASZ, M.D. Dr. Szasz was born in Hungary in 1920. His undergraduate and medical education were at the University of Cincinnati, where he received his A.B. with honors in physics in 1941 and his M.D. in 1944. He interned on the fourth medical service (Harvard) at Boston City Hospital, then had psychiatric residency training at the University of Chicago Clinics and psychoanalytic training at the Chicago Institute for Psychoanalysis. He was in the armed services from 1954 to 1956, stationed at the United States Naval Hospital, Bethesda, Md., and rising in rank from lieutenant to commander. He was a staff member of the Chicago Institute for Psychoanalysis from 1951 to 1956, when he became professor of psychiatry at the State University of New York, Upstate Medical Center, at Syracuse. Besides that position, he is consultant for the Veterans Administration Hospital, Syracuse, for Syracuse Psychiatric Hospital, and for Marey (N.Y.) State Hospital.

Dr. Szasz is a member of the editorial board of the *Journal of Nervous and Mental Disease*, is author of a text, *Pain and Pleasure*, has contributed to a number of other books, and is author of a number of articles in the scientific journals. He is a fellow of the American Psychiatric Association, and a member of the American Psychoanalytic Association and other professional organizations. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

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DAVID M. ENGELHARDT, M.D. Dr. Englehardt is associate professor and acting chairman of the department of psychiatry, State University of New York, Downstate Medical Center, and is acting director of the psychiatric division, Kings County Hospital, Brooklyn. He has been director of the Psychopharmacological Research Unit, State University of New York, Downstate Medical Center since its inception in 1956. The psychopharmacological research unit has been concerned chiefly with the controlled, long-term investigations of psychopharmacological agents. He is currently president of the Brooklyn Psychiatric Society. He is a fellow of the American Psychiatric Association and of the American Academy of Psychoanalysis.

**NORBERT FREEDMAN, Ph.D.** Dr. Freedman's doctorate is from Columbia University and is in psychology. He is now instructor in the department of psychiatry, State University of New York, Downstate Medical Center. He has been on the staff of the Psychopharmacological Research Unit since 1956, and has been associate director of the unit since 1958.

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**LEON D. HANKOFF, M.D.** Dr. Hankoff is an instructor in the department of psychiatry and research psychiatrist with the Psychopharmacological Research Unit, State University of New York, Downstate Medical Center.

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**BURTON S. GLICK, M.D.** Dr. Glick is an instructor in the department of psychiatry and is a psychiatrist with the Psychopharmacological Clinic, State University of New York, Downstate Medical Center.

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**HARVEY E. KAYE, M.D.** Dr. Kaye was formerly an instructor in the department of psychiatry and a psychiatrist with the Psychopharmacological Clinic, State University of New York, Downstate Medical Center. He is now in private practice in New York City. He is a fellow of the American Academy of Psychoanalysis.

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**JULIUS BUCHWALD, M.D.** Dr. Buchwald is an instructor in the department of psychiatry at the State University of New York, Downstate Medical Center. He was formerly a psychiatrist with the Psychopharmacological Clinic, and is now in private practice in Brooklyn.

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**JOSEPH D. LICHTENBERG, M.D.** Dr. Lichtenberg has been clinical co-ordinator at the Sheppard and Enoch Pratt Hospital, Towson, Md. since 1957. Born in Baltimore, he is a graduate of the Johns Hopkins University in 1944, and he received his M.D. degree from the University of Maryland Medical School in 1950. He interned at Lutheran Hospital of Maryland, served for two years at Spring Grove (Md.) State Hospital, and completed a residency at the Sheppard and Enoch Pratt Hospital. He was assistant psychiatrist there, then was medical officer of the supreme bench of Baltimore before he became clinical co-ordinator at Sheppard and Enoch Pratt. He is a candidate in the Baltimore Psychoanalytic Institute and is certified in psychiatry by the American Board of Psychiatry and Neurology. He has previously contributed to this *QUARTERLY*.

ROBERT H. HARDT, M.A. Mr. Hardt has recently been appointed an assistant professor in the department of sociology and anthropology, and a research associate in the Youth Development Center at Syracuse University. He was formerly senior sociologist with the New York State Mental Health Research Unit in Syracuse. Mr. Hardt has studied at Indiana University, Iowa State College, and the University of Michigan. He is currently completing his dissertation at Syracuse University under a fellowship granted by the United States Public Health Service, National Institute of Mental Health. He is a member of the American Sociological Society, the Society for the Study of Social Problems, the Society for Applied Anthropology, and the New York State Public Health Association.

## NEWS AND COMMENT

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### GARDNER TO GIVE HUTCHINGS MEMORIAL LECTURE

George E. Gardner, M.D., director of the Judge Baker Guidance Center, of Boston, and editor of the *American Journal of Orthopsychiatry*, will deliver the eleventh Richard H. Hutchings Memorial Lecture at the College of Medicine, University of the State of New York, Upstate Medical Center, Syracuse, N. Y. at 8 p.m., Monday, October 5, 1959. The lecture is one of a series sponsored by a group of Dr. Hutchings' colleagues and friends. Dr. Hutchings, who died in October 1947, was editor of this *QUARTERLY*. He had been superintendent of Utica and St. Lawrence state hospitals, both in New York, had been president of the American Psychiatric Association, and was professor emeritus of clinical psychiatry at the Syracuse University College of Medicine.

Dr. Gardner is an educator as well as a clinician and editor. Besides his M.D., he holds the degree of Ph.D. in education from Harvard. He is lecturer and clinical professor of psychiatry at Harvard, and is lecturer in psychiatry at Boston University. Dr. Gardner is a fellow of the American Psychiatric Association. He is author or editor of numerous scientific publications, mostly in the field of child psychiatry.

George L. Warner, M.D., director of Craig Colony, New York State institution for epileptics, will deliver the customary short eulogy on Dr. Hutchings, which accompanies the formal lecture. Dr. Warner, as a young physician, served on the Utica State Hospital staff under Dr. Hutchings for seven years.

The memorial lectures are open to all members of the medical profession and to all medical students.

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### JAMES N. PALMER, M.D., QUARTERLY ASSOCIATE, DIES AT 47

James N. Palmer, M.D., New York psychoanalyst and an associate editor of this *QUARTERLY* since 1941, died suddenly in his office in New York City on December 2, 1958. He had been ill for some time. An appreciation on behalf of his fellow editors appears in "Editorial Comment" in this issue of *THE PSYCHIATRIC QUARTERLY*.

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### "YOUR FUTURE" IS NEW DEPARTMENT BOOKLET

A new booklet, "Your Future," on the subject of planning for a person's later years, is being issued by the New York State Department of Mental Hygiene. It was originally printed for a department exhibit at the state fair in Syracuse, N. Y. in September 1958 and has been reprinted for use by agencies and organizations interested in mental health education.

Single copies may be obtained without charge from the Office of Mental Health Education and Information, Department of Mental Hygiene, 240 State Street, Albany, New York.

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#### EDWARD A. STRECKER, M.D., PSYCHIATRIST, DIES AT 72

Dr. Edward A. Strecker, emeritus professor of psychiatry at the University of Pennsylvania Medical School, widely known as a writer both of scientific material and of popular works on psychiatry, died in Philadelphia on January 2, 1959 at the age of 72. He had been ill since September.

Dr. Strecker, born in Philadelphia in 1887, received his medical degree from Jefferson Medical College in 1911. He served a general internship and a psychiatric residency and later went into private practice. He had many consulting and other hospital connections, and in World War I he served in the Medical Corps of the United States Army. He taught at Jefferson Medical College, Yale University Medical School and the medical school of the University of Pennsylvania where he was professor and head of the department of psychiatry until his retirement. He was consultant in psychiatry for the army and for the surgeon general of the navy during World War II. Dr. Strecker was author of the popular book, *Their Mothers' Sons*, in 1951. In that book he developed the thesis that American boys and American character were suffering from "momism." He later collaborated on a companion volume, *Their Mothers' Daughters*. Dr. Strecker was author or co-author of a number of standard textbooks, *Basic Psychiatry*, *Fundamentals of Psychiatry*, and *Practical Clinical Psychiatry*, in the last of which he was co-author with Drs. Ebaugh and Ewalt. Both this book and *Fundamentals of Psychiatry* have run into numerous editions. Dr. Strecker's other writings total some 200 books and articles. He was a life fellow of the American Psychiatric Association and a member of numerous other professional associations. He held honorary degrees from a number of educational institutions, including LaSalle University, St. Joseph's University, Franklin and Marshall, and Boston College.

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#### MEDICAL WRITING AWARDS OFFERED

A \$150 award, to be known as the Karen Horney Award, and to be given for a paper to be published in the *American Journal of Psychoanalysis*, has been announced by the Association for the Advancement of Psychoanalysis. Papers should be submitted by October 31, 1959, and the award will be made at the time of the Karen Horney Memorial Lecture, probably in March 1960. The announcement notes that Dr. Horney pioneered in the integration of various scientific disciplines to deepen understanding of human motivation, and adds that the award will be granted "for such a contribution to the advancement of psychoanalysis."

Another award, unusual in that it aims to encourage "high standards of medical writing," is announced by Modern Medical Monographs (Grune and Stratton). The first prize will be \$500. The contest is restricted to the field of internal medicine and to graduate physicians under 40; entries close October 1, 1959.

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#### NEW YORK STATE COMMISSIONER IS REAPPOINTED

Paul H. Hoch, M.D., New York State commissioner of mental hygiene since 1955, was reappointed to that office by Governor Nelson A. Rockefeller when Governor Rockefeller took office in January 1959. Dr. Hoch has had a long career in the New York State hospital service and was director of experimental research at the New York State Psychiatric Institute when he was first named commissioner by Governor Averell Harriman in July 1955.

An important promotion in the New York State hospital service occurred when Henry Brill, M.D., assistant commissioner of the New York State Department of Mental Hygiene, was named senior director of Pilgrim State Hospital, effective December 4, 1958. Dr. Brill has been in the Department of Mental Hygiene for 26 years and has been assistant commissioner since 1952. He succeeds the late Harry J. Worthing, M.D., as head of Pilgrim. Dr. Brill has been directing the department's division of research and medical services and is continuing to serve as assistant commissioner in charge of that division, pending the appointment of a relief. He is temporarily on leave from Pilgrim where Associate Director Hyman S. Barahal, M.D., is continuing to serve as acting senior director.

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#### EDWIN G. ZABRISKIE, M.D., IS DEAD AT 84

Edwin G. Zabriskie, M.D., former president of the American Neurological Association and the Association for Research in Nervous and Mental Disease, for many years professor of clinical neurology at the College of Physicians and Surgeons of Columbia University, and one of the most active members of the Neurological Institute of New York, died in New York City on January 13, 1959 at the age of 84. Dr. Zabriskie was a fellow and a diplomate of the American Board of Psychiatry and Neurology. His interests included psychiatry as well as neurology and he was a fellow of the American Psychiatric Association. Dr. Zabriskie served in the army medical corps in World War I, taking part in the battle of Chateau-Thierry and in the Meuse-Argonne campaign. He had the rank of lieutenant-colonel. He was a consultant to the United States surgeon general in World War II.

## MENNINGER AWARD GOES TO HARTMANN

The Charles Frederick Menninger Award was presented to Dr. Heinz Hartmann of New York City at the fall meeting of the American Psychoanalytic Association in that city. The award was for Dr. Hartmann's monograph, *Ego Psychology and the Problem of Adaptation*. Dr. Hartmann is a member of the faculty of the New York Psychoanalytic Institute.

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## CLARA THOMPSON, M.D., PSYCHOANALYST, DIES AT 65

Clara Thompson, M.D., executive director of the William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, psychoanalyst, teacher and writer, died on December 20, 1958 at the age of 65. Dr. Thompson was a fellow of the American Psychiatric Association, a member of the American Psychoanalytic Association, a fellow of the Academy of Psychoanalysis and a member of other professional organizations. She was author or editor of a number of books and shorter publications, both scientific and popular. Born in Providence, R. I. in 1893, Dr. Thompson received her medical degree from Johns Hopkins in 1920. After serving an internship and residencies, she studied psychoanalysis in Budapest. She had held her position at the William Alanson White Institute since 1947.

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## SPECIAL COURSES OFFERED IN THE COMING YEAR

A special course in brain functioning, a pioneer educational effort, has been announced by Cornell University to start in September 1959. It will be sponsored jointly by the departments of mathematics, psychology and zoology of the university and will be limited to about 20 graduate and advanced undergraduate students. The formal prerequisite is elementary calculus.

The Sixteenth Annual Summer Seminar-Workshop in General Semantics, conducted by Western Reserve University and the Institute of General Semantics, will be held at the university, August 15 to 31, 1959. A basic course will be offered for teachers, "trainers," research workers and executives.

Other summer educational projects are a workshop in family relations at Syracuse University where a series of short courses will be given from June 1 through August 7; a course in "Introduction to Analytical Psychology for Clinicians" from July 12 through July 24, to be conducted by the University of California at Pacific Grove, Calif. with Bruno Klopfer, Ph.D., co-ordinator; and a three-week "practicum-seminar" for the group theatre of psychodrama at Beacon, N. Y. from July 3 through July 24.

### NEW YORK EXPANDING HOSPITAL AND SCHOOL FACILITIES

Provision for the construction of a \$13,000,000 state school for the retarded, and an appropriation for a \$9,300,000 medical and surgical building for the new state hospital being built in the Bronx are included in Governor Nelson A. Rockefeller's \$257,000,000 budget for the Department of Mental Hygiene for 1959-60. Besides the Bronx building and the new school, other construction provided in the new budget brings the building total to nearly \$26,000,000. The new state school for the mentally retarded is planned to meet a serious situation of overcrowding, plus a waiting list for admissions to the existing state schools. There has been such a list for the last two years. The new school will be constructed in West Seneca, near Buffalo, and will provide over 1,000 new beds for infirm patients.

Mental Hygiene Commissioner Paul H. Hoch, M.D., commenting on the plans for new state construction, remarked that the state hospital admissions were still increasing although the new therapies had brought an increase in discharges large enough for a "slight edge in the balance between incoming and outgoing patients." He added, "Our hospitals are still 22 per cent overcrowded."

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### KAREN HORNEY FELLOWSHIP OFFERED

The American Institute for Psychoanalysis is offering a \$5,000 fellowship in memory of Karen Horney for the full course of psychoanalytic training at that institute. Applicants must be graduates of an accredited medical school and must have completed an approved general internship and two years of psychiatric residency.

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### CHURCH SEEKS PSYCHIATRIST-MISSIONARY

The Board of Missions of the Methodist Church announces that it is looking for a psychiatrist to serve as a missionary in an "important psychiatric institute overseas." The board will accept either a man or a woman, and a certificate in psychiatry by the American Board of Psychiatry and Neurology is required. The board says the person chosen should have "a deep commitment to the cause of Christian missions, and a warm Christian experience."

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### DR. VETHENCOURT HEADS VENEZUELAN SOCIETY

The Venezuelan Society of Psychiatry and Neurology has asked THE QUARTERLY to note that Dr. Jose Luis Vethencourt has been elected president for 1959-1960. Other new officers are: Dr. Pedro Perez Velasquez, vice president; Dr. Eduardo Toro Alayon, secretary; Dr. Alberto Martinez Coll, treasurer; and Dr. Alberto Mateo Alonzo, member of the governing board.

### DR. BORTZ IS 1960 HEALTH FORUM CHAIRMAN

Edward L. Bortz, M.D., former president of the American Medical Association and chief of the medical service of the Lankenau Hospital, Philadelphia, has been named chairman of the 1960 National Health Forum. The forum, sponsored by the National Health Council on behalf of more than 60 member-agencies, will be conducted in 1960 in Miami Beach, Florida the week of March 13. The theme will be "Health of Older People." Dr. Bortz has been active in the study of geriatrics.

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### MENTAL HEALTH INSURANCE PLAN ANNOUNCED

Group Health Insurance of New York City will conduct an exploratory experimental mental health insurance plan beginning July 1, 1959. The project, sponsored jointly by the American Psychiatric Association, the National Association for Mental Health, and Group Health Insurance, Inc., will be limited to a 75,000-person sample group for a two-year study. More than 1,000 psychiatrists in the New York metropolitan area are expected to participate in the study. The subscribers and dependents in the Group Health Insurance "family doctor plan," who will be eligible for the project, will have mental health insurance without increase in their premiums. Services covered include office psychotherapy, electric shock treatments, psychological testing and 30 days of in-hospital care.

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### MEETINGS AND SPECIAL EVENTS SCHEDULED FOR 1959

The American Psychiatric Association annual meeting is in Philadelphia, April 27 through May 1; and the American Association on Mental Deficiency meets in Milwaukee from May 19 through May 23.

One of the outstanding events in the general psychiatric field is the First International Conference on Mental Retardation, in Portland, Me., from July 27 through July 31, with major participants from England, Germany, Austria, France and Denmark. The twelfth annual meeting of the World Federation for Mental Health is scheduled for Barcelona, August 30 through September 5, with the general subject, "Planning for Mental Health."

The National Council on Alcoholism meets in Salt Lake City in March; the New York convention of Alcoholics Anonymous, in New York City in June; and the New York State Association of Mental Health Boards, in Albany in May. The Ninth Freud Anniversary Lecture of the New York Psychoanalytic Institute and Society is scheduled for May 12, with Heinz Hartmann, M.D., as speaker; the Association for Psychiatric Treatment of Offenders has a conference on rehabilitation and therapy on May 14, with the discussion subject, "Delinquency Work in Israel and Norway." The Society of Medical Psychoanalysts is conducting a symposium on dreams in New York City on March 14 and 15, 1959. The spring meeting of the Academy of Psychoanalysis is in Philadelphia, April 24 through April 26.

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